

COUNTWAY LIBRARY



HC 3111 Q

~~THE~~ FRANCIS A. COUNTWAY LIBRARY OF MEDICINE
HARVARD MEDICAL LIBRARY-BOSTON MEDICAL LIBRARY



Digitized by the Internet Archive
in 2015

<https://archive.org/details/indianamedicinej8519indi>

INDIANA MEDICINE

The Journal of the Indiana State Medical Association

January/February 1992

Vol. 85, No. 1



A CLASSIC RETURNS WITH A NEW FOCUS
—“Two Thumbs Up!”

MA 02115
F. A. COUNTESS, JR., M.D.
N.E. JOURN OF MED
10 SHATTUCK STREET
BOSTON

SAFE HARBOR



Smart sailors know where to seek safe harbor. For medical liability protection, Indiana physicians find safe harbor with Physicians Insurance

Company of Indiana, the company formed and owned by the Indiana State Medical Association for that purpose.



“Together, We Make The Difference”

8425 Woodfield Crossing Blvd., Suite 300 Indianapolis, IN 46240 317/469-4100 800/284-7424

INDIANA MEDICINE

STANLEY & GUNTHER
LIBRARY OF MEDICINE
BOSTON, MA
JUN 27 1992

The Journal of the Indiana State Medical Association

January/February 1992

Vol. 85, No. 1

features

Health policy commission sees no easy answers.....12

INDIANA MEDICINE interviews the chairman and two physician members of the Indiana Commission on State Health Policy.

New Medicare formula:

RVU x GAF x CF = ?20

Highlights of the final rules for the Medicare physician fee schedule, released by the Health Care Financing Administration, are discussed.

Gallup Poll reflects Indiana attitudes on health care22

The ISMA's Gallup Poll on health care in Indiana identified opinions regarding the rising costs of health care and patient consent.

ISMA lobbying team plays offense, defense26

In the 1992 session of the Indiana General Assembly, the ISMA will lobby on issues related to AIDS, physician discipline, drug utilization review and INCAP.

Friendly, efficient offices set trend for 1990s28

In this competitive, consumer-oriented decade, physicians are striving for "patient friendly" office design.

Avoiding false starts:

Keys to a successful new practice32

Physicians must run their practices like a business from the very first day.

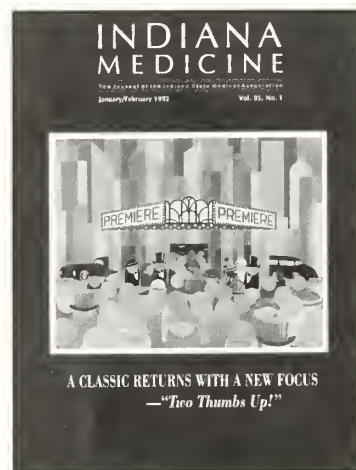
1991 ISMA convention highlights42

1991 ISMA convention coverage46

ISMA Fifty Year Club66

scientific contribution

New alternatives in gallstone treatment34



Cover art from a poster titled "Opening Night" by Carol Dahl, Lakewood, N.J. Cover design by Diane Alfonso of Indianapolis. See page 6 for an editorial on this "premiere" issue.

departments

stethoscope4

editorial6

letter to the editor11

isma leadership92

from the museum93

cme calendar94

obituaries95

drug names95

people96

classifieds98

DIRECTOR

Family Practice Residency Program

SOUTH BEND, INDIANA

Memorial Hospital of South Bend, 526-bed not-for-profit community hospital, seeks a Director for the Family Practice Residency Program, to replace our current Director upon retirement.

Our Program was established in 1970 and is recognized for its strength and the support we enjoy as part of a large acute care facility serving a 17-county area. We are affiliated with the Indiana University School of Medicine; therefore the Director will be granted faculty appointment with the University.

Memorial Hospital's facilities include OB with birthing suites and high risk birthing unit, NICU with hospital-based neonatologist, PICU, ICU, CCU, open heart and other surgical facilities, Emergency/Trauma Center, Radiation Oncology with intraoperative radiation therapy, alcohol/substance abuse treatment and rehab, regional genetic counseling center, and communitywide health education and rehab facility.

This position requires experience in private practice and Board certification with residency training. Preference will be given to candidates with experience in obstetrics. Teaching experience in a fellowship program and a successful administrative record in program development management and community relations are desirable, but we encourage interest from otherwise qualified candidates who lack these qualifications. This is an excellent opportunity for someone with significant knowledge of current and emerging family practice issues and a high level of energy, enthusiasm, and leadership. Salary is commensurate with experience and qualifications.

The position of Director-Family Practice Residency Program will be available January 1, 1992. Applicants should submit a letter of interest and a complete resume to: Elaine Karaszewski, Department of Human Resources, MEMORIAL HOSPITAL OF SOUTH BEND, 615 N. Michigan Street, South Bend, IN 46601. An Equal Opportunity Employer.

Memorial Health System

Working to improve the quality of life.

INDIANA MEDICINE

Devoted to the interests of the medical profession and public health in Indiana since 1908.

MANAGING EDITOR

Tina Sims

EDITORIAL ASSISTANT

Toni Settle

BUSINESS MANAGER

Richard R. King

CIRCULATION

Rosanna Iler

EDITORIAL BOARD CHAIRMAN

George T. Lukemeyer, M.D.

EDITORIAL BOARD

I.E. Michael, M.D.

(Term expires Dec. 31, 1991)

Thomas J. Conway, M.D.

Robert C. Ziss, M.D.

(Terms expire Dec. 31, 1992)

James R. Buechler, M.D.

James W. Edmondson, M.D.

Robert L. Forste Jr., M.D.

George C. Manning, M.D.

Bruce F. Waller, M.D.

(Terms expire Dec. 31, 1993)

Franklin Roesner

Paul Forman

(Medical students)

CONSULTING EDITORS

Steven C. Beering, M.D.

Charles A. Bonsett, M.D.

Walter J. Daly, M.D.

Alvin J. Haley, M.D.

Rodney A. Mannion, M.D.

Alan T. Marty, M.D.

EDITOR EMERITUS

Frank B. Ramsey, M.D.

INDIANA MEDICINE (ISSN 0746-8288) is published six times a year (in January, March, May, July, September and November) by the Indiana State Medical Association. Second-class postage paid at Indianapolis, Ind., and additional mailing offices.

Address correspondence relating to editorial material, advertising or subscriptions to: INDIANA MEDICINE, 322 Canal Walk, Indianapolis, IN 46202-3252. Phone (317) 261-2060 or 1-800-257-ISMA.

Annual subscription rates for nonmembers: \$15 domestic, \$17 Canada, \$18 foreign. Medical library rates: \$14 domestic, \$15 Canada, \$16 foreign. Full-time Indiana medical students: \$7. Single copies not available. Subscriptions are renewable annually.

POSTMASTER: Send address changes to INDIANA MEDICINE, Indiana State Medical Association, c/o Membership Department, 322 Canal Walk, Indianapolis, IN 46202-3252.

Views expressed do not reflect the opinions of the editors. No copyright is claimed, unless specifically indicated. Copyright rests solely with authors, who are responsible for statements in their articles. Scientific and editorial contributions are accepted for exclusive publication, subject to editorial requirements. Instructions for authors available on request.

All issues since 1967 are available on microfilm from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, MI 48106. Indexed in *Index Medicus* and *Hospital Literature Index*.

Advertising rates and data available upon request. INDIANA MEDICINE reserves the right to accept or reject advertising.



To Plan The Most Successful Conference Possible, You Really Should Check All Your Options.

The University Place Conference Center & Hotel offers all the options you should expect to make your conference a success. And, probably a few things you'd never expect. So, if you'd like a free information packet on the features listed, call **800-627-2700**. Because once you've checked us out, you won't even consider any other location as an option.



University Place

Conference Center & Hotel

On the Campus of Indiana University • Purdue University
I N D I A N A P O L I S

800-627-2700

(In Indiana 317-274-3196)

Features	<i>University Place</i>
278-room AAA 4-Diamond hotel	✓
Resources of two major universities	✓
338-seat auditorium with sloped seating	✓
Unmatched A/V capabilities	✓
Award-winning restaurants	✓
385-car underground garage	✓
Full-time A/V staff	✓
Turnkey Conference Planning Service	✓
Skywalk to Olympic-class sports facilities	✓
Thirty soundproof meeting rooms	✓
Two tiered meeting rooms	✓
Videoconferencing	✓
Computerized audience response system	✓
Continuous refreshment service	✓

ISMA representatives discuss INCAP with Terre Haute media

The ISMA is continuing its visits with media representatives throughout the state to discuss the Indiana Compensation Act for Patients (INCAP), the state's medical malpractice law. During a visit to Terre Haute Dec. 18, Jerome Melchior, M.D., Vincennes, and Stephen Tharp, M.D., Frankfort, discussed how INCAP is beneficial to both physicians and patients. Accompanied by Adele Lash, ISMA director of communications, and Mike Brown of Executive Media Communications Consultants, they visited the *Terre Haute Tribune-Star*, television stations WTWO and WTHI and radio stations WBOW and WTHI. ISMA representatives had previously visited Richmond, Valparaiso and Michigan City.

Advance directive booklet available from ISMA

A patient education booklet is now available for physicians, hospitals and health care facilities explaining advance directives and how to make one. The booklet outlines the Indiana Health Care Consent Act, the Indiana Living Will Act and the Indiana Powers of Attorney Act. As of Dec. 1, Congress required all hospitals and health care facilities that receive Medicare and Medicaid funds to inform adult patients on admission of their right to refuse life-sustaining medical treatment. The booklet, written by the Indiana Department of Health, is available from the ISMA at a nominal charge. For a copy, call Toni Settle, (317) 261-2060 or 1-800-257-ISMA.

EPA stops sale of Sporidicin Cold Sterilizing Solution

The U.S. Environmental Protection Agency has issued an order to stop the sale of all batches of Sporidicin Cold Sterilizing Solution (SCSS) product. The EPA action is based on efficacy test data showing that SCSS is not fully effective for destroying spores and thereby possibly other microbial life on inanimate objects as claimed on the label. The solution, made by Sporidicin International in Rockville, Md., was used primarily on selected delicate medical and surgical instruments and equipment in hospitals and other medical, dental and veterinary facilities.

Medical historian/author to discuss "Explaining Epidemics"

Dr. Charles E. Rosenberg, author of "The Care of Strangers, the Rise of America's Hospital System," will speak on "Explaining Epidemics" at 4 p.m. Thursday, Feb. 13, in Emerson Hall at the Indiana University Medical Center in Indianapolis. The program is sponsored by the John Shaw Billings History of Medicine Society. Dr. Rosenberg, a medical historian at the University of Pennsylvania, received the Welch Medal from the American Association for the History of Medicine for his book *The Cholera Years: The United States in 1832, 1849 and 1866*. *The Care of Strangers* was nominated for the Pulitzer Prize in history in 1987. □



Bolander Woods
7644 William Penn Place
North of 75th St. on Sargent Rd.



West 86th
8915 Waterside Circle
West of Zionsville Rd. on 86th St.



Coppergate
10550 Coppergate
West of Ditch on 106th St.



Claybridge
632 Mayfair Lane
126th St. and Spring Mill Rd.

**When you consider
the luxuries in these
homes, it becomes
clear why so very
few are available.**

Four, to be exact.

Paul E. Estridge proudly presents four of the most impressive homes in the area. Now you can indulge in the luxury of one of these magnificent creations and become one of the privileged few.

Call Gary McNutt today
for your private showing,
846-7311.

**Paul
E.
Estridge Corp.**

DESIGNER • BUILDER • DEVELOPER

We also offer an exclusive selection of homesites and custom home opportunities, priced from \$500,000.

Indiana Medicine changing to meet your needs

George T. Lukemeyer, M.D.
Chairman, Editorial Board
INDIANA MEDICINE

With this issue, *INDIANA MEDICINE* embarks on a new phase of its history. The revolutionary changes in the socioeconomics of medical care demand that *INDIANA MEDICINE*'s primary focus change to meet the needs of physicians practicing in today's transitional environment.

Three years ago the Indiana State Medical Association underwent a comprehensive management study. Its goal was to anticipate our members' needs as we approach the 21st century and to position the association to fulfill those needs. During that process, considerable time was spent doing a readership survey of ISMA publications.

The findings were revealing. Our competition is fierce. The 285 physicians surveyed named almost 500 different journals/publications they receive. On a rating scale of one to 10 for measuring the publication's overall value, *INDIANA MEDICINE* was rated a 4.74, the lowest rating of all publications measured. The primary reason for disliking *INDIANA MEDICINE* was "not enough information about my specialty." These findings suggest that more specialized journals better fit the information needs of physician readers.

With our members already receiving a large number of publications targeted toward their

medical specialties and since ISMA represents physicians in every practice specialty, the findings presented us with somewhat of a dilemma. As our survey report stated, "As an organization representing a widespread audience, *INDIANA MEDICINE* runs the risk of delighting no one while attempting to satisfy all. The journal cannot expect to be all things to all members."

Our readership survey bore out some findings that agreed with some other conclusions drawn during the management study. Nobody was doing a good job of informing Indiana physicians about the socioeconomic, practice management, legal, ethical and regulatory issues that impact their practices everyday.

The ISMA Executive Committee appointed a task force to review the readership study and to make recommendations to the Board of Trustees about *INDIANA MEDICINE*. The task force completed its report in August 1990. Among its recommendations were:

- Continue *INDIANA MEDICINE* in a magazine format, but publish six times a year (January, March, May, July, September and November) instead of monthly.

- Emphasize socioeconomic, practice management, legal, ethical and regulatory articles targeted to the specific needs and interests of physicians.

- Include an editorial and/or response in each issue, either sub-

mitted or solicited.

- Editorial board members should peer review submitted scientific articles.

Because of the number of scientific and clinical articles in our files and production schedules, the board approved these changes effective with the January 1992 issue.

Despite the changes, we have kept the door ajar for clinical articles. We still want these articles, just fewer and of higher quality. At least one peer-reviewed scientific article will appear in each issue. And we want your letters to the editor. Many of you harbor strongly held opinions about the competitive environment, about the hassle factor, about Medicare/Medicaid, or even about the joys and sorrows of practicing medicine in modern times. We will be happy to accept suggestions, comments or constructive criticism.

As for this premier issue, you'll find out how the Indiana Commission on State Health Policy views health care reform efforts, including the Canadian System. Highlights of the RBRVS final regulations are here; our article sorts out what they mean for your practice. You'll find out what patients want in your office design. For the traditionalists among you, as usual, ISMA's annual meeting highlights also appear in this month's issue.

We're excited about the changes. We hope our members will be too. □

Over 50 Physicians Have Chosen Our Special Way Of Life.

You could, too.

Since 1917, Caylor-Nickel Clinic has maintained a reputation for excellence. Not only in state-of-the-art patient care and treatment but excellence in our physicians' professional and personal lifestyles.

As a Caylor-Nickel physician, you will benefit from the many advantages of group practice. As a member of a multi-specialty team, you will maximize your income through built-in referrals and by spending far less time on business management.

Over 50 specialty physicians will be on premises for consultation and call coverage. Also housed in the same complex is Caylor-Nickel Medical Center, a 150 bed hospital. Handling rounds and emergencies will no longer disrupt your schedule.

Our fringe package includes a competitive salary guarantee, productivity bonuses, paid malpractice insurance, a new car each year, 28 working days off, and more.

Caylor-Nickel is situated in Bluffton, about 30 minutes from Indiana's second largest city, Fort Wayne. Whether you prefer a quiet country or active city lifestyle, both can be accommodated.

Right now Caylor-Nickel Clinic has openings for physicians specializing in:

- Internal medicine
- Family practice
- Invasive cardiology
- Obstetrics/gynecology
- Orthopaedic surgery
- Anesthesiology
- Endocrinology

If you have an interest, please call Gregg Kurtz, CPC. He'll give you more choice information about Caylor-Nickel's special way of life.

Caylor-Nickel Clinic, P.C.

One Caylor-Nickel Square • Bluffton, Indiana • 46714
1-800-552-2923 in Indiana • 1-800-348-2845 outside Indiana

A#



NEW INDICATION

ONLY ONE H₂-ANTAGONIST HEALS REFLUX ESOPHAGITIS AT DUODENAL ULCER DOSAGE. ONLY ONE.

Of all the H₂-receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage. Axid, **150 mg b.i.d.**, relieves heartburn in **86%** of patients after one day and **93%** after one week.¹

AXID[®]
nizatidine

150 mg b.i.d.

ACID TESTED. PATIENT PROVEN.

AXID[®]

nizatidine capsules

Brief Summary. Consult the package insert for complete prescribing information.

Indications and Usage 1. *Active duodenal ulcer*—or up to 8 weeks of treatment at a dosage of 300 mg b.i.d. or 150 mg b.i.d. Most patients heal within 4 weeks. 2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg b.i.d. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP

Additional information available to the profession on request.



Eli Lilly and Company
Indianapolis, Indiana
46285

NZ-2947-B-249304

© 1991, ELI LILLY AND COMPANY

PHYSICIAN OPPORTUNITY

A Natural Selection

St. Luke's Healthcare Association—a progressive, multifacility healthcare system located in Saginaw, Michigan—currently has private practice and hospital career opportunities for physicians in selected areas of specialization.

The Association provides a complete range of specialty care units, including adult and pediatric intensive care, coronary care and emergency care. We recently opened The Family Birth Center™—a progressive, new, single-room obstetrics unit. And we cooperate in an active residency program

affiliated with Michigan State University's College of Human Medicine.

St. Luke's Healthcare Association is a diverse and growing organization, anxious to meet with physicians interested in pursuing a career marked by a strong administration/physician working relationship and a team approach to patient care.

If you're such a physician, St. Luke's Healthcare Association and Saginaw, Michigan, are natural selections. Contact us today for additional information.

Call or write Jan Gould,
Physician Recruiter:

St. Luke's Hospital
700 Cooper Ave.
Saginaw, MI 48602
1-800-633-3546.



A service of St. Luke's Healthcare Association.
©1991 St. Luke's Healthcare Association. All rights reserved.

**“Faith and Knowledge lean largely upon
each other in the practice of
medicine.”**

Peter Mere Latham

- ♥ Newsletters
- ♥ Medical Writing
- ♥ Audio/Video
Script Writing

Kurt Ullman • Medical Communicators
11078 Huntington Court • Carmel, IN 46032
(317) 843-2065



NO QUITTERS.

We fight nonmeritorious claims. It would be easier to settle, and often less expensive for us. But we're not just insuring your financial future. We're guarding your professional reputation, an asset no amount of insurance could replace. So we put it in writing that we'll never settle without your consent. We hire the best lawyers, back them up with the nation's largest malpractice law department, and win. If we didn't, we couldn't call ourselves The Medical Protective Company. Put us in your corner and call our general agent today.

**THE
MEDICAL PROTECTIVE
COMPANY**

Indianapolis

Vernon E. Hoover
H. Jere Frey, Michael W. Kinzer
(317) 255-6525

Fort Wayne

Robert B. Newell
J. Barton Lyon
(219) 422-4783



■ letter to the editor

Blood shortage

Indiana, particularly Indianapolis, experienced a severe and prolonged blood shortage last summer, as did much of the United States. The causes of this shortage include a generalized fear of donating, the unsupported fear of contracting HIV from donating, previously donating for Desert Storm, increased testing eliminating more and more units every year and the widening breach of the public's confidence in our blood supply caused most recently by the prolonged negative press directed at the Red Cross. Such blood shortages, particularly when chronic, do compromise many patients' care, especially

bone marrow and liver transplant recipients who are completely dependent on adequate amounts of blood and components being constantly available.

Unfortunately, another blood shortage looms this January, when not only blood donations normally diminish, but also Christmas and New Year's occurred mid-week. Consequently, donations will most probably be dramatically reduced during those two weeks and another blood shortage seems very, very likely.

Our goal should be to donate all the blood and components required by patients here in Indiana. Unfortunately, that goal has not been met. All physicians can

and should provide direction and leadership by transfusing patients only when absolutely clinically indicated, encouraging all elective surgical patients to predonate the blood they themselves might require and salvaging and reinfusing blood lost during major surgical procedures. Patients, their families, everyone in the health care field, but especially physicians, should understand the critical importance of this issue and donate blood at least yearly, ideally even more frequently, and lead by example. □

Leo J. McCarthy, M.D.
Indianapolis

Letters to the editor

INDIANA MEDICINE welcomes letters from readers. Please submit double-spaced, typed letters that are limited to 250 words and include your name and address. Letters may be edited for space, style and grammar.

Send your letters to George T. Lukemeyer, M.D., INDIANA MEDICINE, 322 Canal Walk, Indianapolis, IN 46202-3252. □

Health policy commission sees no easy answers

Health care reform is an idea whose time has come. Perhaps the best evidence of that is the prominence of this issue in the 1992 presidential race. Every candidate, including the president, has been obliged to address the electorate's concern about the health of the nation's health care system.

For many voters, it has become a life and death issue. Not just for the 35 million Americans without any health care coverage, but for the millions more who are paying a bigger and bigger chunk of their paychecks for their employee benefit plans. Many large corporations, including the big three automakers, have endorsed national health insurance as a way out from under rising health care insurance premiums.

The national debate, which goes back at least to 1949 when President Truman tried to legislate a national health insurance plan, also has been joined on the state level. Almost every state in the union has appointed task forces, commissions, panels and study groups to examine the health care system from a state perspective and propose strategies for coping with the crisis while the national debate continues.

In May 1989, Indiana Senate Bill 385 went into effect. The bill created the Indiana Commission on State Health Policy to "study and make recommendations regarding the effectiveness and delivery of health care services in Indiana including access to health care, costs of health care and the role of healthy lifestyles and pre-

ventive health care."

The commission began its third and final year of work last November. INDIANA MEDICINE invited commission chairman L. Ben Lytle, president and chief executive officer of The Associated Group in Indianapolis, to talk about the commission's work. He is joined by commission members Joseph Mamlin, M.D., professor of medicine at the Indiana University School of Medicine and chief of medicine at Wishard Hospital in Indianapolis, and Michael Hostetter, M.D., an Indianapolis urologist.

INDIANA MEDICINE: Can you share with us some of the main recommendations in the Health Policy Commission's recent interim report?



Ben Lytle

the way through. One is that no one has really adequately defined and organized, prioritized the problems in the health care system. And it's really quite amazing, when you think about all that's been written, all that's been discussed, the millions of dollars that have been spent on research, probably billions by now, and yet if you ask ... had anyone ever tried to define the problems in the health care system ... the fact is, nobody had. We felt that was

Lytle: There are some 16 findings, and they're all important. I'll touch on a few that have sort of guided and driven us all

fundamental to fixing the problem. Otherwise you have what's occurred in the past, which is that tinkering takes place, which just makes it worse.

Another significant finding was that there's no easy answer, there's no magic answer, that there is no health care system that we've seen, proposed, or if it exists, in another country that gets at the core problems. Nationalized health care systems ration care to the severely ill and the U.S. system rations primary care based on affordability, to a segment of the population that is neither extremely poor nor covered under employer-based insurance. So somebody gets rationed and there's no magic.

In the history of mankind, nobody's ever faced a situation quite like this where daily we invent the ability to improve the quality of life or lengthen life. And our ability to invent far exceeds our ability or willingness to pay. That basic phenomenon we haven't figured out how to deal with yet. And we've had the opportunity to look at, both in documents and in presentations, the health care systems of several foreign countries, and we weren't impressed.

We were required by statute to analyze the Canadian health care system, specifically. We didn't believe that it would do the job for the people of Indiana without rationing care to the severely ill. In addition it would increase state costs by at least two hundred million dollars in 1991-1992.

We also have real concerns about the cost of the Medicaid

program for the state of Indiana. It's going to get a double hit. When you just look at the mandates that are being made by the federal government to expand coverage, that, along with the inflationary pressures, would create a real cost problem for the state. But when you add to that Indiana has a more generous benefit package for participants, you face a doubly troubling health inflation curve in Medicaid. The state is facing long-term serious decisions about the Medicaid program and how it's going to fund it.

We don't know what the answer is yet. We just know that the problem is serious and it's going to be more serious for Indiana than some other states. We don't believe that we know very much about the uninsured in Indiana. There is some national research, but there has been no research done in Indiana on Indiana's uninsured population. The uninsured are a very elusive group. They're a transient group. People stay uninsured for a while and then they move on, so it's very difficult to know what kinds of programs will reach them and what will be effective. One of the things that we have proposed is research on Indiana's uninsured population.

Perhaps one of the more surprising findings for the legislature is that the states really can't do a lot to change their health care system without waivers from the federal government that will allow them to reach more of the

population. If you carve out the federal control over Medicare, the basically federal control over Medicaid, since it pays 75% of the bill, and exemptions for employers that are eligible for ERISA-based programs, then you come down to where the state really only affects maybe 25% to one-third of the dollars.

I'll make one other comment. The popular perception that increased access leads to increased health is not necessarily true. In fact, it's the proper use of access

they're going to be, how we basically have no choice.

It's going to take a fair amount of attention on the part of the legislature and the governor just to find the time to understand it and then to come to grips with the political realities of what it means to try to alter this very complex system. So this is an educational phase for them.

INDIANA MEDICINE: Could you discuss some of the commission's short-term recommendations?

The state is facing long-term serious decisions about the Medicaid program and how it's going to fund it.

Lytle: One was to see if there were any changes that could be made to Medicaid in the short term that could improve the uninsured situa-

tion without creating an even worse cost problem for the state. We are encouraged by the idea of less generous benefits in Medicaid, but being able to cover more people. But we haven't done enough study yet to make that an absolute recommendation.

INDIANA MEDICINE: What are you expecting the governor and the legislature to do with this second interim report?

Lytle: We're not asking them to act on anything. There's no requested legislation at this point. We did make a recommendation that the legislature consider changes to the medical disciplinary commission as a result of the work of one of our subcommittees. But beyond that, we're really asking the governor and the legislature to just begin to digest this very complex problem, begin to understand how difficult the choices we're going to have to make are, how politically difficult

that can lead to better health. And that needs to be foremost in our mind when we start drafting solutions.

The other recommendation we made was on small employer insurance reform. And, essentially, there we're trying to follow the lead of the insurance department. We believe that small employer insurance reform is possible but it runs the risk of increasing costs to part of the employers in order to make insurance available to more small employers. So instead of recommending a specific reform proposal, we recommended certain principles that any reform should follow, and those principles are included in our final report.



Dr. Hostetter

Hostetter: One of the things that I thought was really impressive was the fact that the uninsured problem, although not well studied, is definitely not the indigent population. It's people who often are employed, gainfully employed, but for a variety of reasons ... their employer, or they as individuals cannot afford, or simply can't get, insurance.

Lytle: One of the things that the public and for the most part, state legislatures don't understand is that the laws are conflicting. For example, we say we want small employers to provide insurance to their employees. And yet, if I'm a large employer, I get a 100% tax credit for providing health insurance. If I'm a small employer, I get 25%.

The state legislatures, under pressure from provider groups, mandate coverage that must be provided by small employers, and they make it so expensive that the small employer can't afford to provide coverage. We say we want fewer excess hospital beds, and yet federal antitrust law makes it virtually impossible to merge small hospitals in a mid-size community because it creates an antitrust problem. So what we say we want and our own laws are at odds.



Dr. Mamlin

Mamlin: Even

though we spend our time trying to understand the problems and ponder potential ways of responding to those problems, it's a very difficult environment, as I see it now, in which to be creative. I think it overwhelmed all of us to realize what a small percent of the total health care expenditure that is accessible for Indiana innovation or influence. Very, very limited. So even though we might want to do a great deal with the ideas that come out of this commission, it's going to take partnership at the federal level, that allows creative ideas to be tried.

I think the nation would be served well by a number of states having the waivers and the encouragement to try different kinds of plans rather than waiting for any kind of retrofit of some uniform answer. I think it's time to ... create an environment where innovation and good ideas can be tried.

Hostetter: May I add to that? After two years on the commission, it's very clear to me that the public's perception of the problem [is to] blame the provider system. And I am absolutely convinced after seeing it, that it really isn't totally that. If we want a solution that makes sense, we have to be involved, right now, and be willing to be up front with some real innovative ways to do it because the solutions that are coming along are taking real potshots at us. It's clear to me that they're not going to fix the problem.

That's the message I've tried to give, that clearly we are being blamed for this as providers by the general public. That's a perception, and it's much, much more complicated than that. We

need to be involved to get that message across and be involved in innovative ideas.

INDIANA MEDICINE: *Is there one issue that seems to lie at the heart of health care policy in Indiana or in general?*

Lytle: I think one thing we continue to come back to and that's the treatment of the critically, chronically, terminally ill. That's where somewhere between 50% and 70% of the dollars go, depending upon how you define

**Three to 5%
of the population
consume 50% of all
the health care
resources and
10% consume 75%.**

them. Three to 5% of the population consume 50% of all the health care resources and 10% consume 75%.

That very, very small piece of the population is where all the intensive care, the terminally ill, reside, and we have to deal with that part of the problem. There's more opportunity to deal with that part of the problem because you've got a smaller number of people and you can begin to get your hands around where costs are and how they might be affected.

We have to remember that at the core of all this again is this phenomenon of constantly inventing more than we can figure out

or more than we've been willing, so far, to accept and pay for.

Hostetter: I think one of the things that providers are going to have to work even harder on, although it's been worked on, is outcome measures of some kind, to try to figure out what outcomes we have with varying therapies. It especially has to do with the terminally ill, some of our cancer treatments, some of the things that we do, we really don't have real good outcome measures. We don't know how much we're getting for the dollars spent and what the quality as well as the quantity of life is going to be.

Lytle: It's not clear at all that it's inappropriate for the American people to choose to spend 15% of the gross national product or 20% of the gross national product on improving or extending their life, if they're convinced they're getting value. But if there's any doubt that what that's being spent for isn't producing value, then it becomes an issue. And that's the issue today. People perceive, and we believe there is, a lot of waste in the system, or a lot of care that's not necessarily in the patient's best interest or in society's best interest. But we don't know how to get our hands on it. In the absence of outcome measures, we really don't have any way, other than a lot of subjectivity, to really get our hands on it. And if we can demonstrate value for what people are paying for, then it becomes their decision.

INDIANA MEDICINE: Has the commission gotten to the point of seeing some solutions to the issue of defensive medicine and

the inflationary effect that might have?

Lytle: The long-term solution is the one that Dr. Hostetter already mentioned, which is outcome measures. It serves two roles. One, it establishes value for what's spent. And second, it provides a defense for the provider on what he or she did under certain conditions. So to the degree you can establish outcome measures, you both reduce defensive medicine and demonstrate value for the money spent.

INDIANA MEDICINE: Concerning standards to measure physician performance, who decides what is good and what is bad?

Hostetter: There are many different ways to practice, and I think at the moment, we don't have a good handle on that. One of the hesitations among a lot of pro-

vider groups to put down specific criteria is because we don't have good outcome measures to understand different treatment modalities. It's a little hard to be critical sometimes when we don't have good numbers or good outcome measures.

Mamlin: While we say it's important to have outcome measures or clinical practice assessment type studies, these will be long and hard to develop over time and people need to understand that. A number of these are being funded now at the national level. Frequently we can't get the kind of answers we're looking for in terms of truly a way to approach practice without broad, national types of studies. Those are going on now in the area of hip replacement, knee replacement, congestive heart failure management, diabetes care ... and these will take four, five years to even begin

Members of the Indiana Commission on State Health Policy

L. Ben Lytle, Indianapolis, chairman
State Sen. Virginia Blankenbaker, Indianapolis
State Rep. Charlie Brown, Gary
Thomas Bryant, Jeffersonville
Douglas L. Cocks, Indianapolis
Stanley Deweese, Bicknell
Michael Hostetter, M.D., Indianapolis
State Rep. Douglas M. Kinser, New Castle
Thomas Kramer, Evansville
Joseph J. Mamlin, M.D., Indianapolis
Michael Marchese, Fort Wayne
Joanne B. Martin, Indianapolis
Thomas A. Miller, Indianapolis
State Rep. Donald T. Nelson, Indianapolis
Jerry T. Payne, Indianapolis
State Sen. Kathy Smith, New Albany
Eliza Vela, East Chicago

to get an idea of what kinds of investments of time and technology actually have a positive effect on outcomes or quality of life issues.

INDIANA MEDICINE: **Where, on the commission's list of priorities, would you place education of the public about health care and the limitations of medicine?**

Lytle: We actually put it very high. We had some testimony in our first year from people in the media who had conducted public service campaigns. This is a place where we believe government can play an effective role in educating the public. Perhaps the government is the only one who can do this effectively.

Unfortunately, what occurs today is very little public service advertising about the responsibility that a person has when they use the health care system. Very little is done in the media, other than sensationalist reporting, that recognizes that there is a dual role here of a government or a society to provide access, but there's also a responsibility of the individual to use that access wisely and to make difficult life decisions as if it were their own money, if it's not. And to take care of their health, that there is a linkage between good health behavior and good health.

INDIANA MEDICINE: **To what extent is the current health care situation a result of or a factor of health policy that has focused on remedial efforts rather than prevention?**

Lytle: From a health economics standpoint, prevention is a dual-

edged sword. You can perhaps extend life somewhat, maybe, and if you do then you've got more people with chronic degenerative disease, and health care costs go up with a lot more elderly. So the reason to pursue prevention and a healthy lifestyle is less a health care cost issue than a productivity and a quality of life issue. People should pursue preventive lifestyles or healthy lifestyles because they'll live a more productive and enjoyable life. There's not necessarily any direct linkage to reduced health care costs, with the possible exception of certain isolated cases like prenatal care, where you know you can avoid specific instances of a problem.

Mamlin: I agree completely with what Mr. Lytle has said. One of the things related though in terms of a partnership between a potential patient population and their physician [is] the shrinking pool of primary care physicians, nationally as well as locally, and the important role that is going to play ultimately on both of the issues we've discussed today. The impact it's going to have on cost.

The patient advocate case management kind of coordinating role of the primary physician is crucial with such a complex array of specialty options that are available. And I think that it's the primary physician that is more intimately involved in the issue just raised about the importance of prevention, family education and discussing various lifestyle issues.

Seeing smaller numbers of graduates of medical school choose primary care specialties [is] a trend that's occurred nation-

ally in the last three to five years and seems to be continuing. I think it's very important to this commission and to the state to see if there are incentives or things that could be addressed that would have an impact on that disturbing trend. Because just like the graying of America bodes certain implications for cost, just like the lifestyle issues we've described, I think a significant shift in the reservoir pool of primary physicians available in our system also would be an important factor in what happens both in terms of cost and access to quality of care.

INDIANA MEDICINE: **Are there any factors that are unique to American society that mitigate against good public health?**

Lytle: There are several and I'll comment on one, two or three that jump out immediately.

Drug and alcohol abuse. While every country in the world probably has some element of this problem, the United States has by far the worst that we're aware of.

Violence. We have a level of violence in our society that results in not only traffic into the emergency room but often disability and after-care that's extremely expensive and usually on the public dole.

Accidents. We have an extremely high rate of accidents and accident-related death and injury, compared to Germany, for example, for the same rate of traffic.

Smoking, while that's again a world-wide problem, remains a major problem in the United States.

And last, but certainly not least, we're the most litigious society in the United States and that's

a significant cost factor in the health care system, even though it's not a public health factor.

Mamlin: I would just again like to give significant emphasis to the problem of smoking. We're looking at the loss of more than 400,000 lives on an annual basis within the United States that are directly and indirectly related to smoking. It dwarfs almost anything else we can put forward as a major preventive health care issue.

Hostetter: I want to emphasize one other thing, too. I thought it was really startling testimony that we heard that our teenage pregnancy problem in this country and the lack of prenatal care in teenage pregnancies is unique to the United States. I didn't realize that.

INDIANA MEDICINE: What impact will the graying of America have on the kinds of health care that will be needed and on the funding strategies to pay for them?

Lytle: It's enormous. We heard [that] from every health economist that spoke to us, and one health economist devoted his entire presentation to the cost of the graying of America. And the bottom line of it was, absent changes in what we provide, or the behaviors of the elderly, we cannot afford the baby-boomers when they pass through. They will absolutely bankrupt Medicare and the country. We have no choice.

Something's going to change.

INDIANA MEDICINE: What role can the education of health care professionals themselves play in improving health care?

Mamlin: Physicians in their educational process have so much to learn now compared to 10 or 20 years ago, but it's obvious that our physicians need to learn a great deal about the very issues this commission has been busy studying for the last two years. Because that really has not been an integral part of medical educa-

*... Our physicians need to learn
a great deal about the very issues
this commission has been busy studying
for the last two years.*

tion. Yet physicians are very much involved in a pivotal role in most of the issues that affect cost and outcomes and so forth. But I think that society as well as medical schools need to be very attentive toward trying to encourage our students toward the primary care specialties, creating incentives, creating attractive role models in our medical schools and the various hospitals that show the excitement and rewards involved in primary care.

From an educational point of view, our students need to be exposed to alternative patterns of delivering care. They should learn something about the gatekeeper's role or case management, or prepaid health care systems.

Other than just good science, our physicians should have to be

well-educated as citizens and that means understanding an awful lot about our culture, our political climate, the many things that will affect the kind of health care outcomes that this commission is concerned about. We're only partners with other members of society in trying to solve this problem.

Hostetter: I just want to make one comment. The days of the status quo of the physician practicing medicine have been over for a while. A lot of people still don't recognize that. The key to it is education and involvement. A lot of times that has to be self-education. We have to understand the political environment and understand what's happening

and it takes involvement. You have to be involved in hospital medical staff programs [and] quality assurance programs. It's surprising to me sometimes the lack of involvement with physicians in their own destiny when it comes to that.

INDIANA MEDICINE: Have your perceptions about the state of health care and health care policy in Indiana changed since the commission's inception?

Lytle: Yes, mine have. I thought I understood the health care system pretty well before we went into it and only realized how little I really knew. The problems are far more complex, for more entrenched, and a great deal of them are, more than I ever dreamed,

are outside the health care system. Problems in our society have been "medicalized" and laid at the doorstep of the health care system. But they're not the health care system's problem and you're not going to fix them by making changes to the health care system. Examples: drug and alcohol abuse, smoking, accidents and violence.

INDIANA MEDICINE: What would you say has been the most difficult part of the commission's process?

Lytle: It's been the sheer complexity and enormity of the problem. First of all, for us to be able to just understand how the system

works, understand the problems before you can even begin to fashion solutions. It's extremely difficult for us. Then we have to be able to translate that to the legislators and the governor. ... And we're doing that in an environment where there are large numbers of vested interests who want their solution, [and where the] public is angry and for the most part doesn't understand the complexity of the problem. There is pressure on us constantly to do something that will satisfy all of these constituencies.

It takes some pretty strong-willed people to stay at the task that we set out to do and not get pulled into a political maelstrom or quick fixes that might give people temporary satisfaction but ultimately won't do any good.

INDIANA MEDICINE: What are the issues still to be resolved for the commission's final report in November 1992?

Mamlin: I think even though we have spent these two years learning a great deal, this next year is a formidable challenge. All of us want to reap some benefit from the investment of time and energy to participate in putting forward some possibilities for our legislature and for our citizens to consider.

They ought to have some

*... We're not impressed
by the Canadian system and
don't think it's the answer for the
United States.*

comment about issues of access, issues related to Medicaid, what to do about the catastrophically ill and the chronically ill. What to do with the working uninsured. There are large areas where at least some potential for ideas exists. Ultimately we'll probably have to take a stand for what we think is the most realistic option in each of these areas for the state of Indiana and put it forward and try to defend it.

Hostetter: I think you will see some concrete, probably somewhat controversial, proposals. And I don't think they're going to be what somebody else has done.

INDIANA MEDICINE: What are the reform proposals at the federal level and what do you think of them?

Lytle: The proposals essentially fall into three main categories. There are a group of people that favor a government-run health care system, and their favorite is the Canadian system. As we've said, we've analyzed that system. It rations care to the severely ill, it has a lot of problems and it's presently inflating faster than ours. So we're not impressed by the Canadian system and don't think it's the answer for the United States.

On the other end of the spectrum, you have a group of people led by the Heritage Foundation who believe that you should eliminate all government-funded programs and eliminate the employer-based system of health

insurance and convert to all individual insurance policies. Their basic idea [is] that people will then buy only health coverage that they need. The poor would be provided vouchers to purchase health insurance.

While some of the points they made in their presentation to us made some sense, it completely destroys the system we have and kind of throws it all up in the air and says let's see where it lands. We found that to be perhaps a little extreme, without some test of the principles.

The middle of the road are changing the current pluralistic system to cover the uninsured. That ranges from both mandating employer insurance coverage to incenting employers ...

There are a couple of things that we see that are beneficial to

those types of proposals. One is that it's not a radical change, but again we would state that we don't know that much about the uninsured today, and we're not sure that just mandating employer insurance or providing incentives to provide insurance will even reach all of the uninsured.

More importantly, while all of these proposals have some merit, they're basically changing who pays, not how much they pay. They don't really get at the fundamental inflationary factors in the health care system which are driven by the incentives in the health care system. All they do is try to figure out some way to get it paid for. We think they're all

temporary fixes and they may in fact make it worse. They're really not dealing with this phenomenon that we come back to over and over again: that we're inventing treatment to improve the quality of life or extend life. And we're not coming to grips with how we're going to pay for it, ultimately, and the incentives that are in the system.

INDIANA MEDICINE: Health care is so full of emotion and so complex. Can legislatures and Congress really deal with the reform?

Lytle: I'm not sure if they can. Certainly they're going to be forced to. The question is not

whether or not they're going to deal with reform, but will the reform be positive? I think this has got to be one of the most difficult issues ever faced by our political system. ... What I hope we can do is, as a commission, provide them a level of competence that the issue has been analyzed by a group of people that, as Dr. Mamlin said earlier, are as unbiased as people can possibly be and are trying to get at the real causes of the problems and the best solutions. □

This interview was conducted by Bob Carlson, a health care communications consultant in Indianapolis.

New Medicare formula: $RVU \times GAF \times CF = ?$

The final rules for the Medicare physician fee schedule were released Nov. 25 by the Health Care Financing Administration (HCFA). Highlights of the final rules follow:

1. The conversion factor is \$31.001, compared to \$26.87 in the original notice. This results in a 15% increase.

2. HCFA reworked the off-sets, resulting in a 4.9% base line adjustment. This results in 96.1% of what was proposed in June 5, 1991, Notice of Proposed Rule Making (NPRM).

3. Relative value units (RVU) are based primarily on the work of the Harvard research team. Comments on the RVUs will be received for 120 days after the date of publication of the final rules in the *Federal Register*. Changes will not be made until the 1993 fee schedule is announced.

Formula for computing payments

The payment for Medicare physicians' services must be based on the lower of the actual charge or the payment amount computed under the fee schedule. Payment will be computed as the product of three factors:

1. A relative value for the service
2. The Geographic Adjustment Factors (GAF) for the fee schedule area
3. A nationally uniform dollar amount (CF) \$31.00

The general formula for a payment amount under the fee schedule multiplies an RVU for a service by a GAF for a fee schedule area by a CF. The CF is a

multiplier that transforms relative values into payment amounts.

Under the transition rules, the fee schedule will be phased in from calendar years 1992 through 1995. The phase-in will begin with computation of an adjusted historical payment basis (AHPB) or historical payment amount for each service in each fee schedule area. If the AHPB falls within a range from 85% to 115% of the new fee schedule amount, the new payment will be the new fee schedule amount. If the AHPB is below 85% of the new fee schedule amount, the new payment amount will be the AHPB increased by an amount equal to 15% of the new fee schedule amount. If the AHPB is more than 115% of the new fee schedule amount, the new payment amount will be the AHPB decreased by 15% of the new fee schedule amount.

For example, if the new fee schedule amount is \$20 for a certain procedure:

Example A:

AHPB = \$22. This amount is within the 85% to 115% range of \$20.00, so the new payment amount will be \$20, the full new fee schedule amount.

Example B:

AHPB = \$12. New payment amount = AHPB (\$12) + 15% of new fee schedule amount (15% of \$20).

New payment amount = \$12 + (15% x \$20)

New payment amount = \$12 + \$3 = \$15

Example C:

AHPB = \$24.

New payment amount = AHPB (\$24) + 15% of new fee schedule amount (15% of \$20)

New payment amount = \$24 - (15% x \$20)

New payment amount = \$24 - \$3 = \$21.

4. Geographic Practice Cost Indexes (GPCI) remain the same for Indiana. HCFA is still examining previous studies to reconfigure the existing localities and replace them with alternative payment areas. However, many of the large payment variations that currently exist among localities within Indiana will be substantially reduced by the use of the GPCI.

5. Injectable drug payment will be based on the lower of the estimated acquisition cost or the national average wholesale price of the drug. In the case of multiple sources, the median of the average national wholesale generic prices will be used.

6. There will be a continuation of the recognition of actual time for anesthesia. The national CF for anesthesia services will be \$13.94.

7. As required by the Omnibus Budget Reconciliation Act of 1990, separate payment is no longer made for the interpretation of the following electrocardiogram (EKG) codes if performed as part of or in conjunction with a visit or consultation: 93000, 93010, 93040 and 93042. Payment will still be made for the interpretation of very specialized EKGs under other codes not included within the scope of the statutory provision. Additional RVUs have been added to the office visits, office

consultations, emergency visits, hospital visits, consultations, critical care services, nursing facility visits, nursing home visits and home visits.

8. A standard 90-day postoperative period will include all services by the primary surgeon during this period unless the service is for a problem unrelated to the diagnosis for which the surgery is performed or is for an added course of treatment other than the normal recovery from the surgery.

9. The global fee will include services such as dressing changes, local incisional care and removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and

change and removal of tracheostomy tubes. A list of codes will be provided by the carrier.

10. For minor surgeries and endoscopic procedures, no payment generally will be made for a visit on the same day in addition to the surgical procedure or endoscopy procedure unless a separately identifiable service is furnished. The standard postoperative period of zero to 10 days has been provided.

11. Payment modifiers have an established national payment policy which will affect payment:

- a. Multiple surgery (51)
- b. Bilateral surgery (50)
- c. Assist at surgery (80, 81, 82)
- d. Two surgeons and surgical team (62, 66)
- e. Unusual services (22 or 52)
- f. Multiple modifiers (99)

g. Return trip to the operation room (78)

h. Unrelated procedure by the same physician during a postoperative period (79)

12. The new physician limitation will not apply to the primary care procedures furnished by physicians or to services furnished by physicians in the Health Professional Shortage Area. Payment will be 80% of the fee schedule amount in the first year of practice, 85% the second year, 90% the third year and 95% the fourth year.

There is no longer an exception for physicians who are in a group practice.

If you have questions about the final rules, call Barbara Walker or Marvona Welsh at the ISMA, 1-800-257-ISMA or (317) 261-2060. □

Gallup Poll reflects Indiana attitudes on health care

The Indiana State Medical Association contracted with The Gallup Organization Inc. of Princeton, N.J., to conduct a state-wide assessment of Indiana households regarding attitudes and behaviors toward health care services and issues.

Specific objectives of the study included: 1) to assess the insurance coverage profile of area households; 2) to summarize the Indiana residents' perceptions of the most important issues facing them as they access health care services; 3) to explore several aspects of cost issues relative to health care; and 4) to assess consumers' attitudes regarding HIV and AIDS testing.

Methodology

To meet the above objectives, 1,010 adult heads of household were randomly selected in proportion to the actual number of households within each of the Indiana counties and interviewed by telephone in August 1991. When a randomly selected head of household was not available during the first telephone contact, additional callbacks were made to complete the interview. This callback procedure is a quality-control mechanism for ensuring the randomness of the sample and reducing nonresponse bias. As an additional quality control measure, each survey was individually coded and edited to ensure the accuracy of the data.

Survey instrument development

The Gallup Organization and the ISMA agreed on survey items to be used. The ISMA identified

question areas and information desired, and Gallup wrote items that were technically correct and without bias.

Stability of results

At the 95% level of confidence, the maximum expected error range for a sample of 1,010 respondents is $\pm 3.1\%$. Stated more simply, if 100 different samples of 1,010 people each were randomly chosen from the population, 95 times out of the 100 the total results obtained would vary no more than ± 3.1 percentage points from the results that would be obtained if the entire population were surveyed.

Analysis of results

Data were analyzed across key

demographics including respondent age, race and geographic locations. In addition, counties were classified as urban, rural or mixed. Mixed was defined as those in which a substantial metropolitan area was set in an overall rural area.

Sample characteristics

The average Indiana resident participating in the survey was 47 years old. More than nine in 10 (92%) study participants were white. Nearly half of the participants had some education beyond high school, with nearly one-quarter achieving a college degree. One in nine Indiana residents surveyed had less than a high school diploma. One in eight Indiana households (12%) con-

Table 1

Most important problem facing Indiana residents as they use health care services

Response	Percent
Health care costs	46
Cost of malpractice insurance	3
Cost of insurance	2
Poor insurance coverage	2
Not enough care for poor/homeless	2
Not enough care for elderly	1
Too many uninsured patients	1
Medicare	1
Shortage of physicians	1
Lack of funding/no money	1
Drugs	1
Getting high-quality care	1
Availability	1
AIDS	1
Unemployment	1
Other	10
Don't know/nothing	25

Table 2

**Contributors to rising costs of health care
(n=1,010; three responses)**

	Percent
Physicians charge too much/make too much.....	23
Insurance premium increases.....	9
Increases in hospital costs.....	8
Malpractice/lawsuits.....	7
Increases in technology costs.....	6
Unnecessary use by consumers.....	5
Insurance paperwork/red tape.....	5
Government/Medicare/Medicaid.....	4
Greed.....	4
Increases in labor costs.....	3
Amount spent on terminal patients/last few months of life.....	3
False insurance claims.....	2
Growing number of uninsured.....	2
Increase in prescription costs.....	2
Overcharging (non-specific).....	2
Duplicated services.....	2
Other.....	16
Don't know/refused.....	25

Table 3

**Suggested ways for the government to
keep down the cost of health care
(n=1,010; two responses)**

Response	Percent
Regulate what physicians charge for services.....	22
Regulate what hospitals charge for services.....	18
Have a national health insurance program.....	7
Stay out of it/let private enterprise handle it.....	4
Investigate each case/more monitoring.....	4
Control prices on health care.....	3
Regulate misuse.....	3
Put a cap on malpractice suits.....	3
Control insurance rates.....	2
Educate people.....	2
Provide/encourage preventive care.....	2
Other.....	16
Don't know.....	35

tained at least one member employed in the health care field. One-third (34%) of study participants earned less than \$25,000 per year. The average income reported was just over \$38,000.

Survey results

Because of the survey's length, this issue of *INDIANA MEDICINE* will include only the survey results on cost, HIV testing and life support. Insurance and malpractice responses will be included in the March issue.

Cost

Nearly one-half of respondents indicated that high health care costs is the most important problem facing people in Indiana when accessing health care services (Table 1).

Nearly one-quarter (23%) of Indiana residents indicated that physician fees were the most significant source of rising health care costs (Table 2). Increased costs associated with hospitals, including hospital costs in general, technology costs, and labor costs, were mentioned by one in six respondents. Insurance premium increases and insurance paperwork or red tape were mentioned by one in eight respondents (13%) as significantly contributing to rising health care costs.

What do you think the government, specifically, can do to keep down the cost of health care services? (Table 3)

More than one-fifth (22%) of Indiana residents suggested regulating physician fees, while nearly as many suggested regulating hospital charges (18%) as ways the government could reduce health care costs.

In your opinion, what is the best way to hold down rising health care costs?

More than one-quarter of Indiana residents feel regulations, including government regulations, control of physician and hospital fees, insurance regulation, and general price control are the best way to hold down rising health care costs.

One in 12 respondents (8%) specifically mentioned socialized medicine as the way to resolve rising costs. This response was given significantly more frequently among higher income households (12% mention for average incomes above \$40,000), compared to lower income households (6% mention).

Would you favor or oppose the following as a possible method of slowing down the rise in

health care costs?

Indiana residents were most likely to favor encouraging personal responsibility for health and safety (93%) and having hospitals provide information with regard to fees charged (93%) as ways to slow the rise in health care costs.

Strong support also was found among Indiana households for promoting healthier lifestyles and encouraging people to cut back on alcohol and tobacco use. Reducing the availability of services, closing hospitals and increasing patients' responsibility for hospital service payment were suggestions opposed by most Indiana residents.

Who should be responsible for the health care costs of the people who cannot afford it in your community?

Nearly three in 10 respondents

(29%) believe that the state government is responsible for the health care costs of the medically indigent, while 19% thought this was the responsibility of the federal government. In a national Gallup study of adults, stronger support was found for federal responsibility than was found in Indiana (25%).

Three of five respondents (60%) indicated they were willing to pay additional taxes to defray the costs for the medically indigent. Indiana residents indicated they would be willing to pay an average of \$16 a month for health care services for the medically indigent, but they were significantly less willing to pay additional taxes than found by Gallup nationwide among adults.

HIV/AIDS testing

Have you ever, as far as you know, been tested for HIV or AIDS?

Eighteen percent (18%) of Indiana residents surveyed indicated they had been tested for AIDS or HIV. Incidence of testing was highest among 18- to 24-year-olds (35%). Incidence of having been tested also increased with education; nearly one-quarter (23%) of those who had some college education had been tested, compared to only 13% among those with a high school diploma or less.

Do you think doctors should be required to get a patient's informed consent before they test that patient for HIV or AIDS? (Figure 1)

More than three in five respondents felt that physicians should be required to obtain a patient's informed consent before testing for HIV or AIDS. Support for

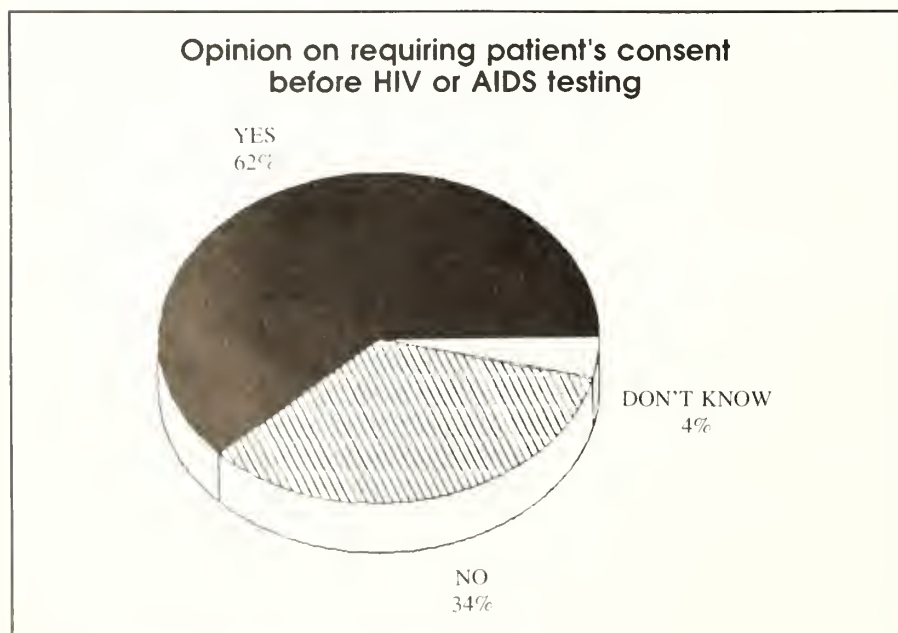


Figure 1

Should people be able to write a living will that indicates they want to be removed from life support systems if they are in a vegetative state or are hopelessly, terminally ill?

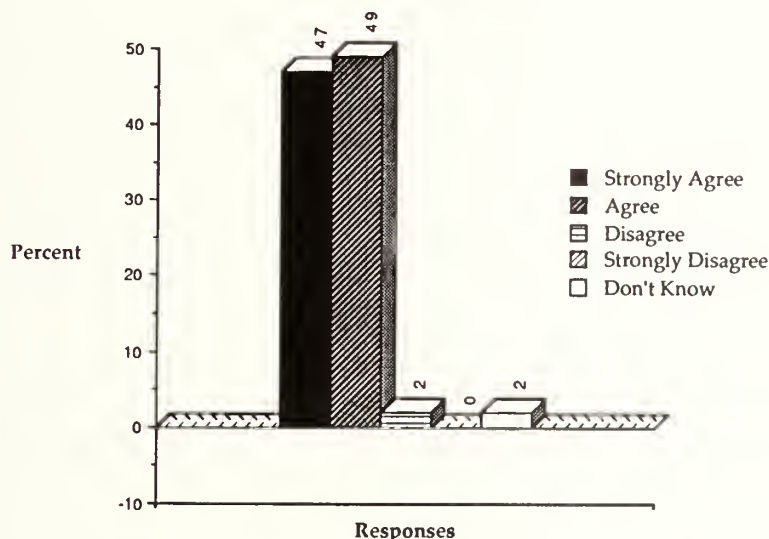


Figure 2

requiring consent was highest among ages 18 to 24, blacks and low-income respondents.

Do you strongly agree, agree, disagree or strongly disagree that

the following should be required to be tested for HIV and AIDS on a regular basis?

More than nine of 10 Indiana residents agreed that HIV and AIDS testing should be required for

surgeons and dentists. Requiring restaurant workers and food handlers, and physicians who don't perform surgery, to be tested also was favored by most respondents.

Life support

Do you strongly agree, disagree, or strongly disagree with the following statements concerning life support and care for those who are terminally ill or are in what is called a "vegetative state." (Figure 2)

Most respondents (96%) agreed that people should be allowed to write a living will specifying the removal of life support systems if the person falls into a vegetative state or is terminally ill. Agreement also was high that intravenous food and water should be withheld under similar conditions. More than one-half (54%) of Indiana residents disagreed that physicians and hospitals should be allowed to decide whether to continue life support for uninsured people in comas or vegetative states. □

ISMA lobbying team plays offense, defense

Mike Abrams
ISMA Director of Marketing/
Legislation

They promise it will be fast and furious. Legislative leaders from both chambers (House of Representatives and Senate) have hinted that the 1992 session of the Indiana General Assembly, which convened Jan. 6, will be a quick one. They will have 29 session days to take care of the state's business, since one session day was used for organizational purposes in November. State law requires this 30-day session to adjourn on or before March 15, but Speaker of the House Mike Phillips says his goal is to finish business by Feb. 15. His goal has important procedural implications; bills will either move quickly out of committee or die.

Why this rush to get out from under the dome? There are two important reasons. First, legislators recall the voters' fury following the 1991 61-day session, which saw the General Assembly adjourn with neither a state budget nor a legislative reapportionment map. Incumbents do not want to face angry voters with a repeat performance when they run for re-election in November 1992. Second, because of the new legislative district maps, many incumbent legislators must go home to face re-election among a

significant number of voters who have never voted for them before. Given this, they need all the time they can get to campaign, and you can't campaign very well from the Statehouse.

ISMA lobbyists are working to see that legislative rubble is kept to a minimum when the short session adjourns. As always, there are many issues on which ISMA will play offense, and many more on which medicine will play defense.

On the offense
AIDS – Indiana physicians continue to voice strong support

consent statute should be repealed. Although legislation has been introduced, it has been unsuccessful during the past two sessions. Vocal opposition from the Indiana Civil Liberties Union (ICLU) has helped make passage of this bill difficult. Fearing that physicians want to routinely test patients so they can deny care to those who are HIV positive, the ICLU always places a high priority on defeat of this ISMA-initiated bill.

Physician discipline – For the past several months, Indiana's Commission on State Health Policy studied Indiana's system of

physician discipline and professional liability. The commission recognized the heightened public awareness that resulted from a Pulitzer Prize-winning series of articles in *The Indianapolis Star*, which indicted

***In the upcoming session,
ISMA will seek passage of legislation to
repeal the special HIV consent statute.
During each of the past three ISMA conventions,
the House of Delegates has affirmed
the position that the HIV consent statute
should be repealed.***

through ISMA's House of Delegates for legislation that would allow physicians to test patients for HIV in the same way as other tests are requested - with general health care consent. Under current law, a physician must document specific consent for the HIV test. In the upcoming session, ISMA will seek passage of legislation to repeal the special HIV consent statute. During each of the past three ISMA conventions, the House of Delegates has affirmed the position that the HIV

the Indiana Compensation Act for Patients (INCAP). ISMA's House of Delegates took a proactive stance at the annual meeting, adopting a resolution calling for changes in the medical disciplinary process. Specifically, the resolution calls for legislation that would allow the medical licensing board to consider medical review panel opinions when cases come before them. The Health Policy Commission recommended legislation requiring the Attorney General to employ a licensed physi-

cian to assist in investigations of consumer complaints.

Drug utilization review – The U.S. Congress adopted federal legislation requiring all state Medicaid programs to implement prospective and retrospective drug utilization review (DUR) programs beginning in January 1993. Prospective DUR provisions will require pharmacists to counsel Medicaid patients on the drugs they are using, while retrospective DUR will require states to notify prescribers whose prescribing patterns fall outside of developed standards and criteria. The retrospective DUR process is intended to be educational, rather than punitive. The ISMA will seek legislation in 1992 that seeks to appropriately implement this law. The bill will establish a state DUR board and outline the board's responsibilities.

Tobacco tax – At the 1991 annual meeting, the ISMA House of Delegates adopted a resolution calling for an increase in the state's tobacco tax (now 15.5 cents per pack), with the increased funding earmarked for health programs. ISMA lobbyists have secured an author for this legislation, but passage will be difficult. Although "sin taxes," such as the tobacco tax, tend to be more popular than most other tax increases, elected officials at all levels of government hesitate to embrace any tax increase. Supporting tax increases contributed to William Hudnut's defeat by Joe Hogsett in the most recent secretary of state race, as well as Louis Mahern's defeat by Steve Goldsmith in the campaign for Indianapolis mayor.

Other – ISMA's 1991 House of Delegates requested legislation

that would establish state oversight of utilization review. Previous position statements will result in the introduction of legislation to prohibit corporal punishment and to regulate mass screenings.

On the defense

INCAP – Protection of the Indiana Compensation Act for Patients remains an ISMA priority. After *The Indianapolis Star* was awarded the Pulitzer Prize for a series of articles on Indiana's medical professional liability system, several legislators publicly suggested that legislative changes should be considered. ISMA leadership and staff have spent much time toward educating legislators about the positive policy impact of INCAP. Rep. Craig Fry (D-Mishawaka) recently mailed a letter to Indiana physicians saying he would use his authority as chairman of the House Insurance Committee to stop legislation that would damage the act.

Generic substitution – The Indiana Pharmacists Association will seek legislation in 1992 that would provide a one-line prescription pad to replace the current two-line ("Dispense as Written" and "May Substitute") pad. The proposal would allow pharmacists to substitute a generic equivalent unless the physician writes, in his/her own handwriting, "Brand Medically Necessary." This requirement is currently in place for all Medicare and Medicaid prescriptions.

HIV – The flood of national attention on Kimberly Bergalis, the Florida woman who died of AIDS in December and who is believed to have been infected by Florida dentist David Acer, led U.S. Sen. Jesse Helms to propose

federal legislation that would have fined and imprisoned HIV-positive physicians who perform invasive procedures without their patients' informed consent. Sen. Helms' proposal almost succeeded. Effective AMA lobbying prevented this from becoming law, but Bergalis' message has had an impact. Although no Indiana legislators have announced that they will seek legislation similar to that proposed by Sen. Helms, it is possible that a similar bill will be introduced.

During the 1991 session, the ICLU attempted to secure enactment of a bill that would have fined physicians \$10,000 per day and charged them with a crime if they refused to treat an HIV-positive patient. The bill nearly passed its committee, with a 5-5 vote. The ICLU may again try to pass such a bill.

Former Speaker of the U.S. House of Representatives Tip O'Neill once said, "All politics are local." Without the vocal, active participation of local physicians, good bills may die, and bad bills may pass.

On Jan. 15, 1992, ISMA will host a "Medicine Day" at the Statehouse. The day will start with a breakfast briefing, where physicians from around the state will hear about late-breaking issues and then spend the day at the Statehouse lobbying their local legislators.

The ISMA makes it easy for Indiana physicians to be active in the policy-making process. For information on how you can become an ISMA Key Contact physician or for information on "Medicine Day," call the Department of Government Relations at 1-800-257-ISMA. □

Friendly, efficient offices set trend for 1990s

**Kathleen Furore
Greencastle**

"Patient-friendly" has become familiar jargon in the medical world of the 1990s.

And physicians are striving to become just that by meeting the needs of patients seeking doctors who practice state-of-the-art medicine, administer large doses of proverbial bedside manner and offer patients the chance to actively participate in the health care they receive.

But in this competitive, consumer-oriented decade, patients' expectations do not begin and end at the exam room door.

As John Battershell, president of Danville-based Battershell and Associates Architects, explains, "Patients' increasingly high expectations of [their] medical care are spilling over into what they expect of the entire space in which that care is administered."

Indeed, patients want each office visit to be a friendly and efficient one from entrance to exit. And, their desires are prompting the most astute physicians, who recognize efficient office design as a competitive advantage, to consider the total environment when selecting or constructing a building or renovating an existing office space.

An emphasis on flow

Pretty pictures, comfortable seating and ambient lighting are often the first things that come to mind when considering ways to make offices appealing to both patients and employees.

Yet architects agree that the importance of cosmetic touches pales in comparison to that of overall flow - the way patients, personnel and practitioners move throughout the office space.

"Flow is absolutely critical," says Battershell, noting that a few steps saved can mean a few patients earned.

"If we can save doctors a few steps on each appointment, they can see one or two more patients each day," he says. "But, because the functions of the office - not its architect - actually create flow, doctors must know how their staffs work and let us know how charts are used, how patients are moved. The more we know about the doctor, his staff and his practice, the better able we are to make the space efficient and friendly."

"Architects have to get input from nurses and the business office manager as well as the doctor," concurs Robert Cochran, owner of Robert A. Cochran and Associates, a company that plans and designs hospitals and medical facilities. "We need to know how doctors want to schedule their patients, how patients are responding and what makes a practice unique to create a better flow."

Facilitating movement between the reception area, staff offices, exam rooms and the exit can be accomplished in myriad ways, depending on the size of the space and the scope of the practice.

At Neurology Associates, a 10-physician Indianapolis practice that moved into a new 11,300-

square-foot building last June, improved flow has come courtesy of scheduling corrals that help break the check-out process into three distinct areas. The building was designed by CSO Architects and Interiors in Indianapolis.

"In our old space, there was a severe bottleneck because patients made return appointments, scheduled outpatient tests at [the adjacent] Community Hospital and paid the cashier at the same window," explains Pam Anderson, business manager of Neurology Associates. "When we designed the new office, we looked at space and floor planning very critically ... and we 'stole' the idea of scheduling corrals from hospitals. Now, we have a counter where patients make return appointments, two corrals where they schedule tests and a separate counter where they pay the cashier. Our efficiency has improved by practically 200% because of patient flow."

The layout of waiting rooms and staff areas also was a priority in the new home of the Indianapolis Fertility Center, a 32,500-square-foot facility created by Indianapolis-based Artekena Design.

According to Jenny Vyain, vice-president of the architectural firm, small sub-waiting rooms, set near the exam rooms one level up from the general reception area, were designed for each of the center's five physicians to expedite patient flow.

"The sub-waiting rooms are small and comfortable with seven to 10 chairs," says Vyain, explaining that patients are called from a

large, general waiting area into the sub-waiting rooms when their physicians are almost ready to see them. "Psychologically, the rooms make patients feel at rest ... they feel more attention is being paid to them."

Consolidating all doctors' charts into a common, convenient area also has improved office flow, notes Leo Bonaventura, M.D., an Indianapolis Fertility Center reproductive endocrinologist.

"We've moved our charts into one central dictation area, so no one has to chase around looking for them," he says. "That [finding charts] can be a problem, especially in offices with more than one doctor."

Clearly, setting up rooms and the routes between them is vital to achieving efficient office flow. But that flow will not be friendly unless patients can easily find their way around, something Anita Barnett, executive vice president of CSO Interiors, says can be accomplished with wayfinding.

"A doctor's office shouldn't be a maze," she comments. "That's why wayfinding, subtly directing patients through the office, is important as it pertains to flow. Signage can be used in large facilities and hospitals ... or you can make a colored accent wall that guides people through."

Waiting room trends

Nowhere is the trend toward patient-friendly practices more evident than in doctors' waiting rooms of the 1990s.

The once formal, forboding, glass-enclosed spaces have given way to rooms that actually impart warmth with their open reception desks, soft lighting, carpeted

floors, comfortable seating and overall home-like feel. And, in many offices today, there even is someone who greets patients as they enter the general reception area.

"A friendly image is very important ... and a very easy way [to achieve it] is to bring the receptionist out and make her the 'hello person,'" says CSO's Barnett.

"The psychology of the space ... must be welcoming," agrees Battershell, noting that a doctor's patient-friendly image will be enhanced simply by having an employee greet patients as they come through the door.

Image, of course, also is reflected in the decor selected for the waiting area.

And, while specific colors and artwork depend on the personal taste of each physician, there are general trends emerging in office decor, according to architects who specialize in medical office design.

Color-enhancing lights, comfortable but durable furniture, attractive but resilient carpeting and warm, soothing colors are among the decade's burgeoning trends, according to Cinda Terry, a director at CSO.

"There is a trend toward ambient lighting, often cove lights in the ceiling," Terry says, explaining that this type of indirect illumination provides a soft glow because light bounces up off the ceiling, then down into the waiting area.

She also notes that a combination of overhead and table lighting typically is used in reception areas to avoid an institutional feel and that fluorescent lights, which have been improved to enhance natural skin tone, often replace the less energy-efficient incandescent lights that once were used

because of the more natural light they cast.

Furniture, too, is key to waiting room comfort. And, though it must be fashionable, it also must be functional, durable and appropriately placed to create an efficient as well as friendly environment.

"Fabrics must wear well ... especially in a family practice," says Sherri Holm, an interior designer/space planner at CSO Architects and Interiors. "So ask if they are removable and cleanable, if they pill, if they show wear and stain. And consider treating them with a [stain-resistant] finish."

Holm's colleague Cinda Terry recommends olefin as a fabric to consider for office waiting areas because of the fabric's proven durability.

"Olefins used to be ugly, but they've been perfected now and are very attractive and stain-resistant," Terry says.

Even something as simple as furniture placement can contribute to a patient-friendly space according to Vyain and Battershell, who advise steering clear of large, sterile groupings of waiting room chairs.

"At the Indianapolis Fertility Center, we placed the [waiting room] furniture in smaller groupings to get away from a bus station-like feel," says Vyain, who designed the space with a lot of glass for natural light and added plants for a fresh, airy feel.

"I've spent a great deal of time and effort trying to keep from having rows of people staring at each other," comments Battershell, who accomplished his goal at Indianapolis Orthopaedics' office in Danville, where he created "a long, skinny, V-shaped waiting area" in full view of the

general office.

The floor covering on which furniture rests is another factor to consider when selecting waiting room decor. Carpeting is the big trend, though CSO's Terry suggests resilient, level loop carpet as opposed to the more "cushy" cut pile that crushes quickly in heavy office traffic. She also recommends adding transition strips where flooring materials change between office spaces.

Characteristics of specific practices also must be taken into account when choosing office decor, according to the professionals at CSO.

Terry, Holm and Barnett say neurologists, whose patients often have headaches and focusing problems, should watch for carpet and wall covering patterns such as herringbone that can cause dizziness; avoid abrupt changes in contrasting colors and floor heights; and provide subdued lighting in waiting areas.

Geriatric specialists, they say, should offer relatively high light levels, dusty pastel colors (especially soothing for Alzheimer's patients) and avoid furniture that's comfortable but too soft to easily get out of.

Staff spaces

To make offices truly friendly and efficient, staff work spaces must be paid the same attention as the rooms designed specifically for doctors and their patients.

And that means designers must focus on everything from charts and office equipment to the furniture in which nurses, cashiers and business personnel sit - things that are especially important in the computer age.

"More office space is needed today than when employees

worked with just a typewriter and an 8-by-11 sheet of paper," comments Brent Hussong, project Manager at AbleRingham Architects in Indianapolis. "Space that once accommodated 1.5 people now only holds one efficiently ... and that's a fact that's often ignored."

Hussong emphasizes that designers "must know about all electronic gizmos in an office, even fans, pencil sharpeners and desk lights," to efficiently place electrical outlets throughout the work space.

Helen Battershell, office manager at Battershell and Associates Architects agrees, offering as evidence the reception center her husband installed at Hendricks Community Orthopedics and Sports Medicine: The state-of-the-art countertop boasts built-in electrical outlets that accommodate office equipment and help conceal unsightly phone, fax and computer wires.

Consolidating equipment, the way Artekna Design did at the Indianapolis Fertility Center, is another way increasingly complicated practices are improving the efficiency of their office staffs.

"As physicians take on more staff, it becomes more important to group them together so they can share resources," says Vyain. "Duplicating copiers, fax machines and computers is unnecessary ... even if technicians and nurses are spread throughout the office, it saves time and money if they can bring (information) back to one area."

Filing systems are also a major concern for doctors' employees. And CSO's Barnett identifies movable files, which were installed at Neurology Associates and can be moved to make space

for additional cabinetry, as a recent and growing trend.

Staff furniture, too, has become increasingly important in light of legislation on the East and West coasts regarding the use of video display terminals (VDTs) and ergonomic furniture. And, though Barnett says requirements for "healthy" office furniture, seating that promotes correct posture and places VDTs at distances determined safe for regular users, will likely take three to five years to hit the Midwest, she advises doctors to install ergonomic furniture now to avoid costly renovations in the future.

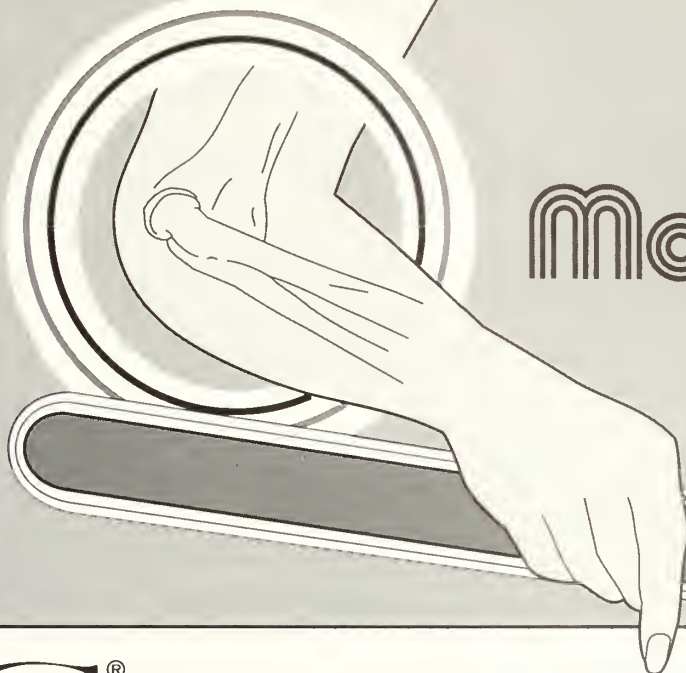
The impact of the ADA

Perhaps no single factor will impact office design as much as The Americans With Disabilities Act (ADA), which takes effect July 26.

Architects involved in programming and designing medical office spaces are watching closely to determine exactly how the new federal law will affect their clients. And, though they're not jumping into renovations because they say the legislation is rather vague and undefined, they are making new offices accessible to patients who are physically impaired in any way.

"All the law says is that existing spaces need to incorporate changes that are readily available, but that's hard to interpret," says Barnett. "The biggest impact will probably be on restrooms, but it will [probably] include things like water fountains, telephones and signage. Everything [doctors] provide for the non-handicapped, they'll have to provide for the handicapped, too." □

Kathleen Furore is a freelance writer living in Greencastle.



SAFE
EFFECTIVE
CONVENIENT
ECONOMICAL

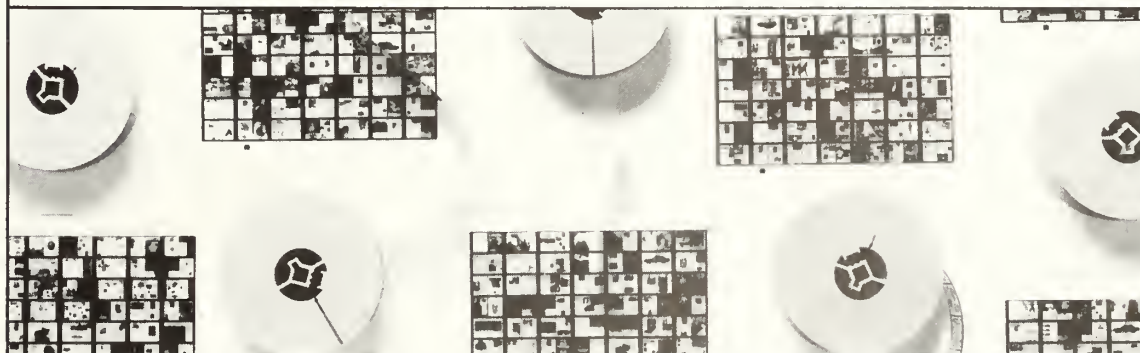
Mono-Gesic[®] R Tablets
(750mg Salsalate)

A well tolerated
Salicylate Therapy



CENTRAL[®] CENTRAL PHARMACEUTICALS, INC.
SEYMOUR, INDIANA 47274 USA
Quality Pharmaceuticals Since 1904

This publication is available in microform.



UMI reproduces this publication in microform: microfiche and 16 or 35mm microfilm. For information about this publication or any of the more than 16,000 periodicals and 7,000 newspapers we offer, complete and mail this coupon to UMI, 300 North Zeeb Road, Ann Arbor, MI 48106 USA. Or call us toll-free for an immediate response: 800-521-0600. From Alaska and Michigan call collect 313-761-4700. From Canada call toll-free 800-343-5299.

U·M·I

A Bell & Howell Company
300 North Zeeb Road, Ann Arbor, MI 48106 USA
800-521-0600 toll-free
313-761-4700 collect from Alaska and Michigan
800-343-5299 toll-free from Canada

Please send me information about the titles I've listed below:

Name _____
Title _____
Company/Institution _____
Address _____
City/State/Zip _____
Phone (_____) _____

Avoiding false starts: Keys to a successful new practice

Ernest Condra
William Metzger, CPA
Indianapolis

Just like an athlete, it is critical for physicians opening a new practice to avoid false starts. False starts only work against the practice and can serve to damage its long-term profitability and productivity.

What types of false starts are there to avoid? Listed below are false starts that may sound familiar:

- Missing withholding tax deadlines or not properly withholding employee taxes.
- Running into a legal scrape over the terms of your lease or purchase of a facility.
- Not fully understanding the contract terms or financial consequences of HMO or PPO arrangements.
- Not knowing how to prepare and present a business plan to a lender.
- Not planning enough for the financial aspects of starting your practice (e.g., How long do I have to wait from time of service until I receive payment? How much should I pay my employees? What financial effect does accepting Medicare assignment really have anyway?).
- Simply put, not running your practice like a business.

If there is one overriding concept that you should remember, it is that you must run your practice like a business from the very first day. The days of simply practicing medicine without much business or management knowledge have long passed. With some rare

exceptions, the environment in which you will practice medicine is becoming increasingly complex, requiring ever-increasing business knowledge. There are a few ways in which you can approach this situation:

- 1) Forge ahead as if it were still the good old days. **Not recommended.**
- 2) Enter into an agreement in which a management company or hospital will manage your office while you practice medicine. **You pay a price for this service.**
- 3) Spend your own time learning those things you need to manage and then doing so. **You can generate more revenue practicing medicine than practicing management.**
- 4) Rely on others to help you achieve your goals. **This is really the most effective management technique — getting things accomplished through other people.**

The crux of the issue, then, becomes learning what the priority items are and to whom to entrust each task. Most of the early issues that you will face will revolve around a group of key people. Begin to think of making investments in people for which you will receive significant dividends over time. This key group is comprised of your:

- Banker
- Attorney
- Accountant and/or financial consultant
- Office manager and staff

Roger Penske of Indy Car and corporate management fame has an appropriate view on how to manage. He says, "I worry about the details [of what I know how

to do]. I hire people smarter than me to worry about the big things." Using that same strategy in your practice simply means that you can worry about the details of practicing medicine and not spend time attempting to control details in areas as disparate as law, accounting, Medicare funding and human resources administration. In the long run, you'll be more efficient and more satisfied with your practice.

There are a few general rules to follow when establishing these relationships:

- 1) Look for people with experience in health care settings.
- 2) Make sure that you are comfortable with both their qualifications and personalities. You're looking for a long-term arrangement.
- 3) Tell them everything. Don't keep secrets.
- 4) Tell them your goals and let them help prescribe the methods.
- 5) Trust their judgment.

After establishing these key relationships, one of the first decisions will be to select an entity form: sole proprietorship, professional corporation or partnership. Here you will address some important legal and tax issues with your attorney and financial advisor.

It is critical, then, that one of your next actions be to project the financial status of your new practice. Every decision you make will have an effect on your ultimate financial status. Going through the exercise of business planning with your financial advisor will force you to evaluate every component of your new busi-

Table

	Staff	Potential Involvement		
		<u>Legal</u>	<u>Financial</u>	<u>Banking</u>
Ownership type determination		X	X	
Site selection		X		
Lease/purchase evaluation		X	X	
Business plan preparation			X	
Loan request			X	X
Equipment purchase/lease	X	X	X	
Telephone co./equipment choice	X		X	
Supplies purchase	X		X	
Risk management (insurance)		X	X	
Managed care participation		X	X	
Medicare participation		X	X	
Staff interview/selection	X	X	X	
Personnel training	X		X	
Employee/retirement benefits	X	X	X	
Accounting system automation	X		X	
Marketing activities	X			
Financial reporting	X		X	X
Partnership contracts		X	X	
Medical records	X	X		
Billing practices	X		X	

ness. Items such as location, competition, marketing, personnel, office management, equipment and capital requirements will all require answers. To help you with some of these decisions, consider the issues listed in the *Table*. If you need help with any aspect of these items, remember to call your closest advisors early in the process.

By establishing relationships early with a nucleus of advisors familiar with your unique needs, false starts can be avoided. The lack of these false starts will allow you to spend more time doing what you enjoy - practicing medicine. □

Ernie Condra is director of health care services and a manager in the Management Consulting Services Department of George S. Olive & Co. in Indianapolis. Bill Metzger is a tax partner providing tax and accounting services for physicians and medical groups for George S. Olive & Co.

New alternatives in gallstone treatment

Richard Graffis, M.D.
Lee Jordan, M.D.
James E. Lingeman, M.D.
Mary Beth Moster
Indianapolis

For nearly a century, the treatment of choice for gallbladder stones has been surgical cholecystectomy. This treatment has proved generally safe and effective, although not without morbidity and mortality.

In recent years, advancements and refinements in medical technology have allowed the development of laparoscopic cholecystectomy (LCC), a new surgical approach to the removal of the gallbladder in which the gallbladder and the stones are removed through a small abdominal incision. LCC has proved as safe as traditional surgical cholecystectomy, without the discomfort, extended hospital stay and lengthy recuperation associated with a large abdominal incision.

Another new surgical approach is percutaneous cholecystolithotomy (PCCL), in which the gallstones are removed through a percutaneous tract and the gallbladder is left intact. This approach, while it has proven safe and effective, has seen limited use.

Several new non-surgical therapies, some of which have received media attention and

some of which have been marketed to the general public, include extracorporeal shock wave lithotripsy (ESWL), peroral drug chemolysis and methyl-tert-butyl ether (MTBE) lavage.

These new treatments and their relative merits and disadvantages, compared to each other and to standard cholecystectomy, are described in this article.

Prevalence and symptoms

Gallbladder disease resulting in gallstones is a common condition. The risk for gallstones is higher for women than for men and increases with age. Lifetime prevalence for women is 10% to 15%; for men it is 5% to 10%.

Only about 20% of people with gallstones have symptoms. Those gallstones discovered incidentally generally do not become symptomatic. Currently, definitive treatment usually is withheld until symptoms do occur, except

Abstract

Within the past few years, a number of new treatment modalities for gallbladder stones have become available. Laparoscopic cholecystectomy has proved as safe as traditional surgical cholecystectomy, without the discomfort and lengthy recuperation associated with a large abdominal incision. Several other new treatments also have been investigated, including percutaneous cholecystolithotomy, peroral drug chemolysis, extracorporeal shock wave lithotripsy, and methyl-tert-butyl ether lavage. The relative merits and disadvantages of these treatments, compared to each other and to standard cholecystectomy, are described herein.

in certain exceptional cases such as transplant patients with compromised immunosuppression. Even so, more than a half million people in the United States are treated with surgical cholecystectomy each year.

Gallstone composition

Until now, the composition of gallstones has been of relatively little clinical importance, inasmuch as the removal of the gallbladder along with the stones eliminated the possibility of recurrent stones. Now, however, some of the newer treatment alternatives leave the gallbladder intact, increasing the risk of recurrent stones. Composition also is an important factor when considering medical dissolution. Currently available agents are effective only for cholesterol stones, but most gallstones are mixtures of cholesterol crystals, calcium crystals and amorphous organic

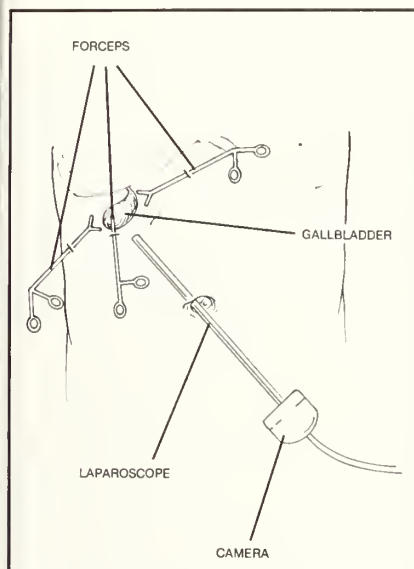


Figure 1: Laparoscopic cholecystectomy involves the use of a laparoscope to visualize the interior of the abdomen, so small caliber instruments (inserted through three "stab" incisions) can be utilized to manipulate, dissect and secure the structures necessary for the removal of the entire gallbladder.

matter. Only 31% of gallstones in the series of Sutor and Wooley were composed solely of cholesterol.¹ Therapeutic selection is complicated by the fact that stone composition is difficult to predict with investigational modalities available today.

Surgical cholecystectomy

Cholecystectomy has been the treatment of choice for symptomatic gallstones for most of this century.

John Stough Bobbs, a self-trained Civil War surgeon from Indianapolis, was the first physician to offer definitive treatment for gallstones. On June 15, 1867, in a third floor room over Vinton

and Kiefer's store in downtown Indianapolis, he performed the world's first reported cholecystolithotomy. Mary E. Wiggins, a 30-year-old woman, was near death at the time of the procedure; she survived. In 1905, 37 years after the historic procedure, Bobbs was presented the American Medical Association award for distinguished service.² The first elective cholecystolithotomy was performed in 1878,³ and the first cholecystectomy in 1882.⁴ Between 1880 and the early 1920s both cholecystolithotomy and cholecystectomy were widely used to treat symptomatic gallstones.

In 1911, William J. Mayo, M.D., published a landmark paper⁵ that urged prompt surgical treatment of both symptomatic and asymptomatic gallstones and encouraged cholecystectomy in preference to cholecystolithotomy. By the 1920s, cholecystectomy had become the treatment of choice for gallstones, a position that has remained unchallenged until now.

Though surgical cholecystectomy has a long track record of relative safety and efficacy, the advancements and refinements in surgical technology and medical therapy have allowed the development of alternative treatments.

Laparoscopic cholecystectomy

At Methodist Hospital of Indiana, Richard Graffis, M.D., and Earle Robinson, Jr., M.D., began developing a procedure for the laparoscopic removal of the gallbladder in February 1988. At that time, information about such a procedure was limited to anecdotal reports from Europe. The techniques used in laparoscopic gynecologic surgery were adapted for the removal of the gallbladder. Since that time, more than 700

patients have been treated with this method at Methodist Hospital.

Basic technique: Many of the surgical principles important in open cholecystectomy (e.g., exposure, hemostasis, tissue identification) are also vital in LCC. However, the laparoscopic approach requires techniques that may be unfamiliar to many surgeons.

The instrumentation used in LCC is either borrowed from or adapted from instrumentation used by the pelviscopist. These instruments give the surgeon the ability: 1) to access the interior of the abdomen through puncture wounds, 2) to view the procedure on video, 3) to manipulate and retract organs within the abdomen, 4) to identify and dissect pertinent structures, 5) to evaluate the bile ducts radiographically, 6) to obtain hemostasis and to irrigate, and 7) to place drains through the puncture wounds (Figure 1). All of these tasks can be accomplished without making a major abdominal incision.

The procedure is performed in the operating room. The patient receives general anesthesia and is appropriately monitored. After the abdomen is prepared and draped for surgery, pneumoperitoneum is established via a Veress needle passed through a 1-cm incision in the umbilicus. A 10-mm trochar/sheath is then inserted at that site for passage of the laparoscope with attached video camera.

Accessory 5-mm trochar/sheaths are then placed into the peritoneal cavity at three sites along the right costal margin. Through these ports, the various structures are manipulated, dissected and secured, much as they are in the open technique, but under video guidance and with

markedly different instruments and approaches. The cystic duct is secured by surgical clips or standard ties. The cystic artery is similarly secured and cauterized. If appropriate, a cholangiogram is done through the cystic duct prior to ligating it. The gallbladder is removed from the liver bed by small scissors, cutting cautery, or various lasers. The gallbladder is then aspirated of its bile and removed from the abdomen (along with its contained stones) through the approximately 1-cm (depending on the size of the stones) umbilical incision.

In some cases, the degree of inflammation of the gallbladder or the status of the common duct may be unknown. In these cases, it may be prudent to survey the situation laparoscopically and abandon LCC in favor of the open technique, if the situation warrants. A moderately inflamed gallbladder can be removed laparoscopically if the cystic duct and common duct areas lend themselves to accurate identification, dissection and control. Any condition that would rule out safe utilization of the laparoscopic instrumentation (e.g., diaphragmatic hernia, pregnancy, serious abdominal adhesions) would also obviate LCC.

Patients are encouraged to walk within a few hours of surgery, and a regular diet is offered the same evening. Rarely are more than one or two injections of analgesics required, and oral analgesics are usually needed only for a day or two, if at all. Patients generally are released with no restrictions from the hospital the evening of the day of surgery or on the first postoperative day. Most patients are able to return to

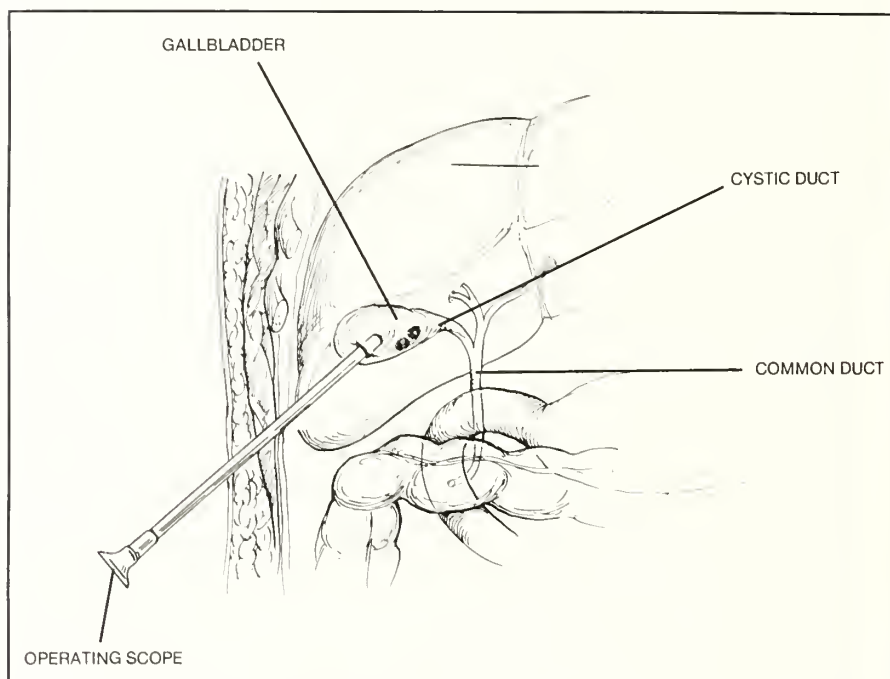


Figure 2: The PCCL procedure uses x-ray and ultrasound to locate the gallbladder. A small needle is placed through the skin and into the gallbladder. A passage is created between the skin and the gallbladder with a balloon catheter. Through the passage, an operating scope is placed into the gallbladder. Small gallstones are removed with a vacuum or grasping instruments. Larger stones are crumbled with ultrasound, electrohydraulic or laser energy, then the particles are removed.

work within seven days, regardless of occupation.

Results: More than 400 laparoscopic procedures have been performed by one author (R.G.). Of these patients, the treatment for seven had to be converted to an open cholecystectomy, four because of intense inflammation of the gallbladder, one because of anatomic variation, one because of an obliterated peritoneal cavity caused by adhesions, and one because of common duct stones not amenable to transphincter extraction.

There were no abdominal infections or hemorrhages. Forty-five patients had acutely inflamed or hydropic gallbladders. Nine patients weighed more than 300 pounds. Five patients had prior upper abdominal surgery, and 80 patients had prior lower abdominal surgery.

In this series of patients, the procedure was found to be safe, effective and well-tolerated by patients.

Laparoscopic cholecystectomy is playing an increasingly important role in the management of

the patient with symptomatic gallstones. Although LCC is a relatively new surgical approach, the results indicate that it can be as safe as open cholecystectomy, and LCC offers several advantages. LCC is becoming widespread in its use, and patients report a high degree of satisfaction with the procedure.

Percutaneous cholecystolithotomy

Percutaneous cholecystolithotomy (PCCL) as a primary treatment for gallstones (Kellett et al⁶) is another new endoscopic technique for eliminating gallstones. The techniques for the PCCL procedure evolved primarily from the experience gained from percutaneous access to the kidney for a variety of urologic problems. Urologists, general surgeons and radiologists

worked together to develop a percutaneous technique by which gallstones could be removed and the gallbladder could remain intact (Figure 2).

The initial worldwide experience with PCCL is small but favorable and suggests that PCCL is less morbid than open cholecystectomy, inasmuch as the hospital stay is briefer, analgesic use less, and postoperative time for convalescence to full activity is shorter.⁷

Basic technique: The patient is placed in a 30° semi-Fowler (head-up) position to assist caudal displacement of the transverse colon. A C-arm fluoroscope and/or an ultrasound unit are used for visualization of the gallbladder. An 18-gauge needle is used to access the gallbladder transperitoneally, and bile is aspirated to confirm access. Contrast material

is injected to aid fluoroscopic imaging of the gallbladder. A .035-inch floppy tip guidewire is coiled in the gallbladder, and dilators and a balloon catheter are then used to dilate the abdominal incision and the gallbladder opening.

After access is gained, a cannula is placed, through which various endoscopes are passed. Small stones may be removed with grasping forceps. Larger stones are fragmented with electrohydraulic, laser or ultrasound probes.

Fifteen patients were treated with this technique between October 1989 and February 1990. All patients were rendered stone free, and none required open cholecystectomy. The average length of hospital stay was 2.4 days, and all patients were successfully treated with a single procedure, except one individual who had a cystic duct stone remnant requiring a secondary procedure. Two of the 15 patients had cystic duct stones; the remaining patients had gallstones only. Several patients in this series had significant coexisting disease processes that made them poor candidates for traditional cholecystectomy. One patient was quadriplegic, and five patients had severe cardiac and/or pulmonary disease significant enough to increase their risk for undergoing an abdominal incision. Four patients were operated on under local anesthesia and tolerated the procedure without difficulty.

This approach, while it has proven safe and effective, has seen limited use compared to LCC.

Other therapies

Peroral drug chemolysis: Oral bile acids have seen limited use in this

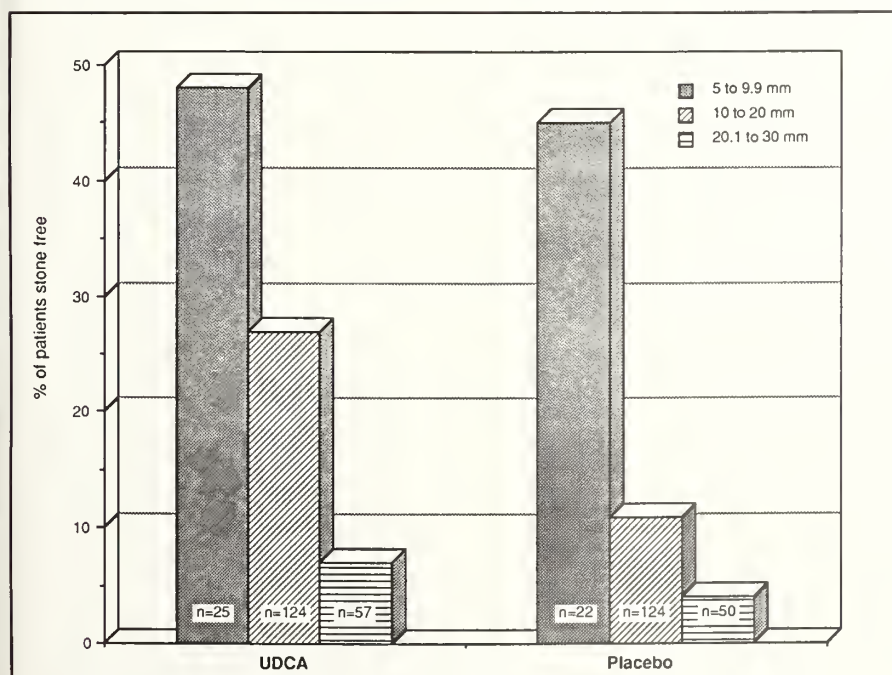


Figure 3: Percent of patients free of stones six months after ESWL. (Maximum diameter of stone, in mm, at baseline.)

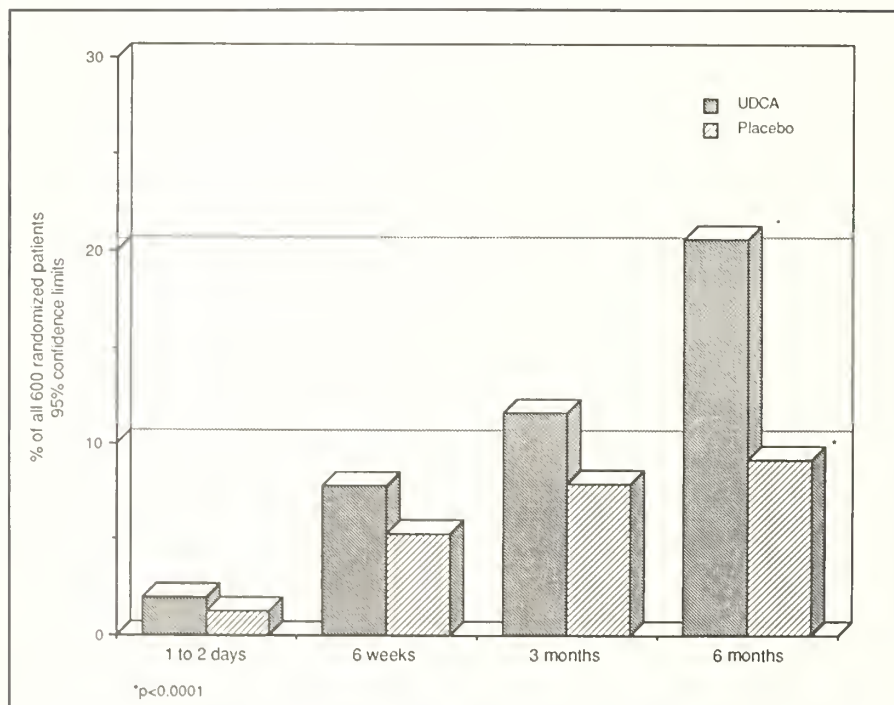


Figure 4: Percent of patients free of stones after ESWL, at one to two days, six weeks, three months and six months.

country. Most biliary stones cannot be completely dissolved with oral bile acid treatments, because they are not pure cholesterol. Two bile acids, chenodeoxycholic acid (CDCA) and ursodeoxycholic acid (UDCA), are available for clinical use at this time, but initial trials with these agents have shown disappointing dissolution rates, and the therapy requires six to 24 months of therapy. Patients with mild biliary colic can be treated with peroral drug chemolysis, but those with more severe colic or those who have had complications such as pancreatitis or acute cholecystitis should not be treated with this therapeutic approach.

Extracorporeal shock wave lithotripsy: Gallbladder lithotripsy

has not been approved by the FDA for use in the United States. A summary of European experience recently was published.⁸

Based on results of our studies and other clinical trials, some general impressions can be drawn. Biliary lithotripsy is safe for patients and effective in fragmentation, but it is a treatment modality that seems best applied to a small group of patients within the gallstone population. Stone-free results from our trial are shown in Figure 3 and Figure 4. Small, single stones respond best to treatment. Treatment with UDCA clearly improves the stone-free rate.⁹

Methyl-tert-butyl ether lavage: Percutaneous transhepatic lavage of gallstones with methyl-tert-

butyl ether (MTBE) requires transhepatic access to the gallbladder via a small caliber cannula placed percutaneously. Though MTBE may be a more efficient solvent than earlier lavage agents,^{10,11} dissolution still occurs only with cholesterol stones. The technique usually requires several hours per day for several days. MTBE is a potent sedative, an irritant to bowel mucosa and nephrotoxic. Thus, lavage must be closely monitored to prevent loss of MTBE down the bile ducts, into the liver, into the blood stream or into the peritoneum.

Because of these difficulties, this treatment modality is of only minor importance at this time.

Cost of treatments

Determining the physician/hospital cost for one treatment modality compared to another is a complicated equation involving much more than the amount charged to the patient.

Generally, however, the charge to the patient will be about the same for traditional surgery, PCCL, or LCC (all of them ranging from \$4,000 to \$8,000). Oral dissolution may be less expensive in the short term, but, because of stone recurrence, surgery ultimately may be required, thereby increasing the cost.

PCCL and LCC provide a savings to the patient in terms of a quicker recovery with faster healing and less discomfort, allowing a speedier return to full activity and employment.

Risk of stone recurrence

Both surgical and laparoscopic cholecystectomy effectively eliminate the risk of recurrent stones in the gallbladder. Even so, a slight

risk of recurrent stones in the biliary ducts remains. PCCL, ESWL, and chemical litholysis leave the gallbladder *in situ*, and the risk of recurrent gallstones following these new treatment alternatives must be addressed¹² (Table 1).

Data from the trials in Europe and from trials where oral dissolution is used suggest 10% per year recurrence for the first four to five years¹³ (Table 1).

Several additional factors may affect the recurrence rate, all of which need further study. These factors include low fat diet, low dose oral bile acid and aspirin or other nonsteroidal anti-inflammatory drugs.

Conclusion

Surgical cholecystectomy has been the treatment of choice of symptomatic gallstones for most of this century; however, new treatment alternatives may offer advantages to a significant number of patients. A summary of the features and some of the advantages and disadvantages of the traditional and new treatment alternatives are provided in Table 1.

Despite the explosion of new alternatives for gallbladder therapy, our current treatment of choice remains the removal of the gallbladder, either surgically or laparoscopically. However, certain categories of patients may be better suited for alternative treat-

ment options.

Endoscopic techniques: Both LCC and PCCL offer several significant advantages over open cholecystectomy, including less pain medication required, earlier ambulation, shorter length of stay in the hospital, earlier return to work, fewer physical limitations in the postoperative period, and less incisional pain. Because PCCL does not require general anesthesia, this treatment may be preferred for some patients.

Although LCC is a relatively new surgical approach, the results indicate a low complication rate, and this technique offers several actual advantages to open cholecystectomy. The procedure

Table 1. Features of Treatment Alternatives

	Observation	Cholecystectomy	Drug Chemolysis*	SWL (+) Drugs	MTBE Lavage	PCCL	LCC
Candidates							
Symptomatic patient		✓	✓	✓	✓	✓	✓
Type stone	any	any	cholesterol	cholesterol	cholesterol	any	any
No. of stones	any	any	any	≤ 3	any	any	any
Stone size	any	any	≤ 15 mm	≤ 25 mm	≤ 20 mm	any	any
Ca # in stone	OK	OK	N/C§	N/C§	N/C§	OK	OK
Pigment stone	OK	OK	N/C§	N/C§	N/C§	OK	OK
Rx Experience							
No. of pts treated	>10 ⁶	>10 ⁶	> 10,000	> 5,000	100 to 200	< 1,000	< 25,000
Rx painful	sometimes	yes	no	sometimes	moderate	slight	slight
Rx uncomfortable	sometimes	yes	no	sometimes	sometimes	slight	slight
Rx duration	mo to yrs	2 to 8 wks	mo to yrs	months	2 to 5 days	2 to 10 days	1 to 2 days
Probability of SF§	none	~100%	15% to 80%	20% to 80%	~90%	~100%	~100%
Long-term drugs	no	no	yes	yes	?	no	no
Risk of recurrent stones	---	<1%	$\frac{50\%}{5 \text{ yr}}$ ¹⁴	?*	?*	$\frac{20\% \text{ to } 30\%}{20 \text{ yr}}$ ¹³	<1%

*Estimate of risk of recurrence may parallel risk after drug (only) chemolysis.

†Non-candidate, if present.

§Stone free.

is becoming widespread in its use, and patients relate a high degree of satisfaction with this method.

Unlike other techniques in which the gallbladder is not removed (chemolysis, ESWL plus chemolysis, or MTBE), PCCL is useful with all types, numbers and sizes of gallstones. With PCCL, all stones are removed from the gallbladder in a single procedure that does not require general anesthesia. PCCL also gives access to stones and to bile, thereby opening the door to sophisticated stone analysis and biochemical evaluation of bile to assess the risk of recurrence.

PCCL is not appropriate for small contracted gallbladders that contain little or no bile and that may image unsatisfactorily.

Shock wave lithotripsy: Although biliary lithotripsy is not yet approved by the FDA, early results suggest that it is a safe treatment modality that in time might be best applied to a small group of patients within the gallstone population. Dissolution of the fragments with oral bile acids will play an important role in particle elimination.

Stone dissolution: At present, peroral drug chemolysis can be a successful treatment for a compliant patient with small stones. MTBE lavage is cumbersome and inefficient and of only minor usefulness.

The therapeutic armamentarium for the treatment of gallbladder stones has been expanded, but the usefulness of the various therapies varies widely. □

Dr. Graffis is a surgeon, Dr. Jordan is an internist and Dr. Lingeman is a urologist at Methodist Hospital of Indiana in Indianapolis. Ms. Moster was the editorial consultant on this manuscript.

Correspondence: Lee Jordan, M.D., Methodist Hospital of Indiana, 1801 N. Senate Blvd., Suite 400, Indianapolis, IN 46202.

References

1. Sutor DJ, Wooley SE: A statistical survey of the composition of gallstones in eight countries. *Gut*, 12:55, 1971.
2. Cutter IS: Landmarks in surgical progress: John Stough Bobbs and lithotomy of the gallbladder. *Int Abst Surg*, 47:409, 1928.
3. Sims JM: Remarks on

cholecystostomy in dropsy of the gallbladder. *Brit Med J*, 1:811, 1878.

4. Langenbeck C: Ein fall von Exstirpation der gallenblase wegen chronischer cholelithiasis. *Heilung Berl Klin Wchnschr*, 19:725, 1882.

5. Mayo WJ: "Innocent" gallstones: A myth. *JAMA*, 56:1021, 1911.

6. Kellett MJ, Wickham JEA, Russell RCG: Percutaneous cholecystolithotomy. *Br J Med*, 296:453, 1988.

7. Griffith DP, Gleeson MJ: Percutaneous cholecystolithotomy: A logical progression of endourological techniques. *J Endourol*, 3(1):11, 1989.

8. Sackman M: The Munich gallbladder lithotripsy study results of the first five years with 711 patients. *Ann Intern Med*, 114(4):290-6, 1991.

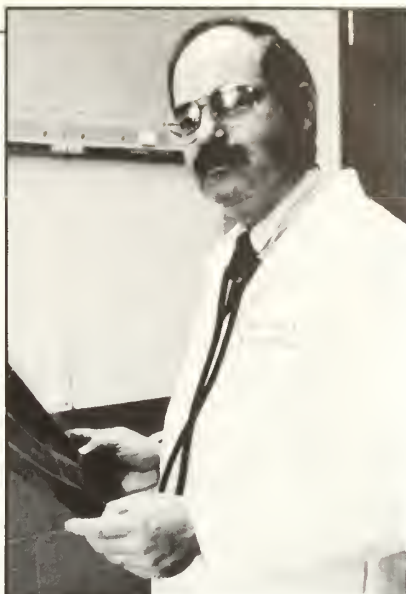
9. Schoenfield L, et al: The effect of ursodiol on the efficacy and safety of ESWL of gallstones: the Dornier national biliary lithotripsy study. *N Engl J Med*, 323(18):1239, 1990.

10. Allen MJ, Borody TJ, Bugliosi TF, et al: Cholelitholysis using methyl-tert-butyl ether. *Gastroenterol*, 88:122, 1985.

11. Thistle JL, May GR, Bender CE, et al: Dissolution of cholesterol gallbladder stones by methyl-tert-butyl ether administered by percutaneous transhepatic catheter. *N Engl J Med*, 320:633, 1989.

12. Pers M, Baden H: On the frequency of recurrence of calculi in the gallbladder after cholecystolithotomy. *Act Chir Scand*, 102:260, 1951.

13. Salen G: Clinical perspective in the treatment of gallstones with ursodeoxycholic acid. *J Clin Gastroenterology*, 10(suppl) 2:S12, 1988.



Sure...

you're a good physician, but can you write?

Most physicians today need more than knowledge of medicine and good clinical ability to be successful. One of the tools you need is the ability to write well: to be able to put together a report of research that's worth publishing, to write a grant proposal that's fundable, to prepare a paper or exhibit for presentation that's well received.

We don't guarantee that you'll write a best seller or get a million-dollar grant, but we can guarantee that if you join us, you'll learn how to improve your writing, enhance the quality of your presentations, and keep up-to-date with developments in areas like desktop publishing.

We're an organization founded by physicians 50 years ago, and we're over 3000 strong. Among our members are people like you, for whom writing has become an increasingly important part of life. Find out more about us.

Send this coupon or call AMWA's national office at 301-493-0003.

Executive Director, AMWA
9650 Rockville Pike
Bethesda, MD 20814



Please send information about AMWA to:

Name _____

Address _____

Title (or specialty) _____

City _____ State _____ Zip _____

YOCON[®]

YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

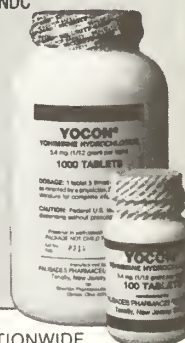
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

**PALISADES
PHARMACEUTICALS, INC.**

219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

1991 ISMA convention highlights



C. Dyke Egnatz, M.D., receives the ISMA President's Medallion from Michael O. Mellinger, M.D., outgoing ISMA president, at the President's Night Dinner. Looking on are their wives, Jamie Mellinger, left, and Bonnie Egnatz.



C. Dyke Egnatz, M.D., addresses the crowd during the President's Night dinner after his installation as ISMA President.



Chris Matthews, a national syndicated political columnist for *The San Francisco Examiner*, speaks at the annual IMPAC luncheon.



Glyn A. Porter, a student at the Northwest Center for Medical Education, I.U. School of Medicine, received first place in the scientific exhibits.



James A. Trippi, M.D., an Indianapolis cardiologist, received the ISMA Physician Community Service Award. In 1988, he founded the Gennesaret Free Clinic of Indianapolis, which provides free medical care, medicine and medical supplies to the homeless and needy.

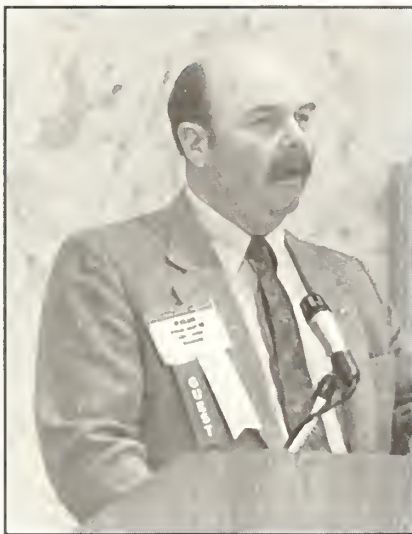


Members of Reference Committee 1 are, from left, Bernard Emkes, M.D., Indianapolis; Dennis Egnatz, M.D., Elkhart; Susan Pyle, M.D., Union City, chairman; James Daggy, M.D., Richmond; and William Vaughn, M.D., Vincennes.

Ken Stella, president of the Indiana Hospital Association, discusses the IHA's data collection activities during the special session segment of the convention.



Delegates, from left, Leon J. Michl, M.D., Madison; W.R. Rucker, M.D., Madison; and Arthur Jay, M.D., Lawrenceburg, wait for the opening session of the House of Delegates.



William Jacott, M.D., an American Medical Association trustee from Minnesota, speaks at the opening session of the ISMA House of Delegates.



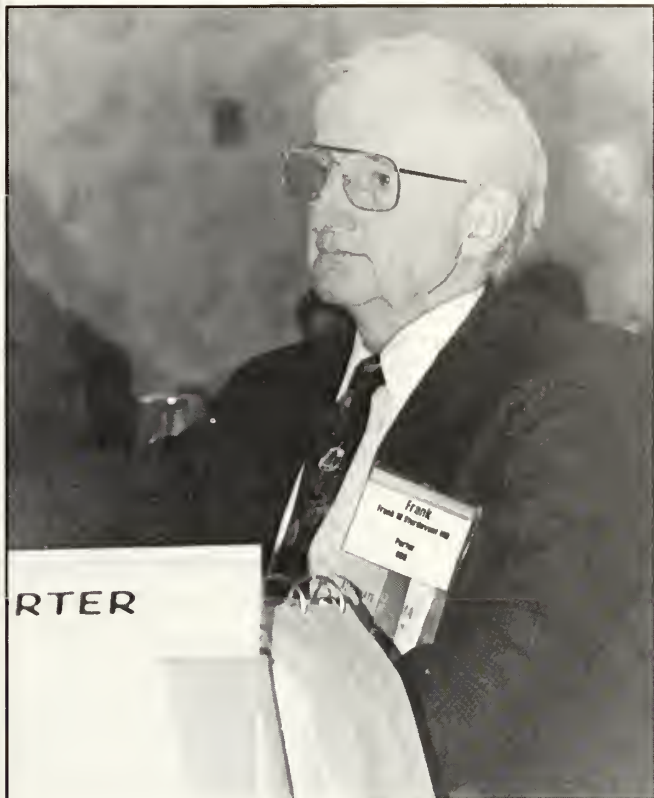
Linda Mangels, director of the office of risk management for the Texas Medical Association, answers questions from Everett Bickers, M.D., Floyd's Knobs, center, and William Mohr, M.D., Kokomo. Ms. Mangels presented a seminar on risk management.



Delegates waiting to receive their credentials are, from left, John Seward, M.D., Bedford; Davis Ellis, M.D., Indianapolis; Shirley Khalouf, M.D., Marion; and Eugene F. Senseny, M.D., Fort Wayne. Staffing the credentials table are Richard A. Schaphorst, M.D., South Bend, and Rosanna Iler of the ISMA.



Richard Houck, M.D., Michigan City, visits the Van Ausdall + Farrar exhibit, staffed by Brian Zeitz.



Frank M. Sturdevant, M.D., of Valparaiso listens to proceedings during the opening session of the ISMA House of Delegates.



Attending the Indiana Roentgen Society meeting are, from left, Kathleen Dockery, past president of the Indiana Radiology Business Management Association; John Meissner, IRBMA president; and Mike La Masters, IRBMA board member.



Jerome Tamler, right, of RANAC Computer Corp. discusses his company's products with Richard M. Spalding, M.D., of Sellersburg.



Robert Morgan, right, a student at the Indiana University School of Medicine, visits the Eli Lilly/Dista Products Co. exhibit staffed by George Mills of Dista and Michelle Bartick of Lilly.

1991 ISMA convention coverage

Call to order, miscellaneous business

The Indiana State Medical Association House of Delegates convened its 142nd Annual Convention at 9 a.m., EST, Friday, Nov. 8, 1991, at the Westin Hotel in Indianapolis. The final session of the House of Delegates convened at 9 a.m., EST, Sunday, Nov. 10, 1991.

Presiding at both sessions was William H. Beeson, M.D., speaker, Indianapolis, assisted by William Van Ness II, M.D., vice speaker, Summitville. Helen Czenkusch, M.D., Indianapolis, served as parliamentarian. Paul Riley, M.D., Indianapolis, presented the invocation.

Approval of minutes

The proceedings of the 141st Annual Meeting of the House of Delegates, Indiana State Medical Association, conducted Nov. 2-4, 1990, at the Radisson Hotel, Indianapolis, and published in the January 1991 issue of *INDIANA MEDICINE*, were approved.

Addresses/reports

The addresses of the president, president-elect, president of the ISMA Auxiliary and the dean of the Indiana University School of Medicine (all referred to Reference Committee 1) were filed with commendation.

All reports (printed in the October 1991 issue of *INDIANA MEDICINE*) and additional supplemental reports were filed, with the exception of the treasurer's report, which is referred for audit.

Election of officers

C. Dyke Egnatz, M.D., Schererville, president-elect, suc-

ceeded to the office of president. William H. Beeson, M.D., Indianapolis, was elected president-elect. Other elections included:

Treasurer – John Bizal, M.D., Evansville

Assistant treasurer – Timothy Brown, M.D., Crawfordsville

Speaker of the House – William Van Ness II, M.D., Summitville

Vice speaker of the House – William Cooper, M.D., Columbus
Chairman, Board of Trustees – Peter Winters, M.D., Indianapolis

Clerk/chairman pro tem,
Board of Trustees – Jerome Melchior, M.D., Vincennes

At-large member, Executive Committee – Alfred Cox, M.D., South Bend

At-large member, Executive Committee – Jerome Melchior, M.D., Vincennes

Election of delegates, alternate delegates to the AMA

The following were elected to two-year terms as delegates and alternate delegates to the American Medical Association (terms expire Dec. 31, 1993).

Delegates:

Marvin Priddy, M.D., Fort Wayne

John MacDougall, M.D., Beech Grove

Herbert Khalouf, M.D., Marion

Alternates:

Michael Mellinger, M.D., LaGrange

George Rawls, M.D., Indianapolis

Richard Reedy, M.D., Yorktown

Holdover AMA delegates and

alternate delegates (terms expire Dec. 31, 1992) are:

Delegates:

George Lukemeyer, M.D., Indianapolis

Alvin J. Haley, M.D., Carmel
John Knotte, M.D., Lafayette

Alternates:

Edward Langston, M.D., Indianapolis

Max Hoffman, M.D., Covington

Shirley Khalouf, M.D., Marion

A standing ovation from the House of Delegates was accorded Peter R. Petrich, M.D., Attica, for his past service to the Indiana delegation to the American Medical Association.

Trustees/alternates, 1991-1992

The House of Delegates confirmed the newly elected/re-elected trustees and alternates, 1991-1992.

Trustees:

District 1 – Bruce Romick, M.D., Evansville

District 2 – Jerome Melchior, M.D., Vincennes

District 3 – Gordon Gutmann, M.D., Jeffersonville

District 4 – Arthur Jay, M.D., Lawrenceburg

District 5 – Fred Haggerty, M.D., Greencastle

District 6 – Ray Haas, M.D., Greenfield

District 7 – Donna Meade, M.D., Indianapolis

District 7 – John Records, M.D., Franklin

District 7 – Peter Winters, M.D., Indianapolis

District 8 – John Osborne, M.D., Muncie

District 9 – Stephen Tharp, M.D., Frankfort

District 10 – Nicholas Polite,
M.D., Hammond
District 11 – Jack Higgins,
M.D., Kokomo
District 12 – John Thomas,
M.D., Fort Wayne
District 13 – Alfred Cox, M.D.,
South Bend
RMS – Rick Robertson, M.D.,
Indianapolis
MSS – Andre Stovall, Indian-
apolis

Alternate trustees:

District 1 – Barney Maynard,
M.D., Evansville
District 2 – James Beck, M.D.,
Washington

District 3 – John Seward,
M.D., Bedford
District 4 – Robert Forste,
M.D., Columbus
District 5 – Roland Kohr,
M.D., Terre Haute
District 6 – Howard Deitsch,
M.D., Richmond
District 7 – Ronald Blanken-
baker, M.D., Indianapolis
District 7 – Bernard Emkes,
M.D., Indianapolis
District 7 – Charles
McCormick III, M.D., Greenwood
District 8 – Susan Pyle, M.D.,
Union City
District 9 – Robert Darnaby,
M.D., Rensselaer

District 10 – Frank Sturdevant,
M.D., Valparaiso
District 11 – Laurence Mussel-
man, M.D., Marion
District 12 – Charles Frank-
houser, M.D., Fort Wayne
District 13 – Richard Houck,
M.D., Michigan City
RMS – Carla Brumbaugh,
M.D., Carmel
MSS – Ruchir Sehra, Indian-
apolis

Future meetings

1992 Oct. 16-18 Westin
1993 Oct. 15-17 Westin
1994 Oct. 21-23 Westin □

In memoriam

Tribute to the members of the Indiana State Medical Association who have died since the 1990 session.

Carlos M. Antonio, M.D., Highland
Wilbur P. Beeson, M.D., Greenfield
Frances T. Brown, Indianapolis
Alan R. Chambers, M.D., Bay St. Louis, Miss.
Philip A. Christiansen, M.D., Indianapolis
John E. Conley, M.D., Fort Wayne
Robert L. Costin, M.D., Indianapolis
Robert W. Currie, M.D., Bradenton, Fla.
Marvin R. Davis, M.D., Indianapolis
Walter E. Deacon, M.D., Indianapolis
David J. Dukes, M.D., Corydon
Joshua L. Edwards, M.D., Indianapolis
Stephen C. Ferguson, M.D., Evansville
Ray Firestein, M.D., South Bend
Warren E. Fischer, M.D., Anderson
Carl A. Freed, M.D., Indianapolis
Donald A. Gerrish, M.D., Terre Haute
Lois G. Godersky, M.D., South Bend
Charles J. Hillenbrand, M.D., Michigan City
James M. Himler, M.D., Indianapolis
Ronald H. Hull, M.D., Indianapolis
Robert G. Husted, M.D., Cedar Lake
James E. Keplinger, M.D., Lafayette
Jay M. King, M.D., Logansport
Joseph W. King, M.D., Anderson
Lewis C. Lohoff, M.D., Tell City
Donald H. McCartney, M.D., Indianapolis

Marvin L. McClain, M.D., Scottsburg
Cecil G. McEachern, M.D., Fort Wayne
James R. McLaughlin, M.D., Flora
Robert J. Milos, M.D., Portage
Michael O. Monar, M.D., Rockport
Hilbert M. Mueller, M.D., South Bend
Martin J. O'Neill, M.D., Valparaiso
Roy V. Pearce, M.D., Terre Haute
Emma J. Peden, M.D., Indianapolis
Max E. Pfuetze, M.D., Logansport
Charles A. Reid, M.D., Indianapolis
Katherine K. Rice, M.D., Mishawaka
Floyd C. Riggs, M.D., Greencastle
Isidore Rochlin, M.D., Indianapolis
Jacob Rosenwasser, M.D., Mishawaka
Leo Roth, M.D., La Jolla, Calif.
Barton J. Rusk, M.D., Carmel
Francis G. Sheehan, M.D., Indianapolis
Jack E. Shields, M.D., Brownstown
Herschel S. Smith, M.D., Bloomington
Jesse S. Spangler, M.D., Kokomo
Jerry L. Stucky, M.D., Fort Wayne
Mary A. Surratt, M.D., Indianapolis
George V. Teter, M.D., Carbon
George T. Tindall, M.D., Indianapolis
Malachi C. Topping, M.D., Naples, Fla.
Byron C. Wheeler, M.D., Indianapolis
Morton F. Wolfe, M.D., New Albany
Donald J. Wolfram, M.D., Indianapolis
Frank H. Zahrt, M.D., LaPorte
Evertson H. Zell, M.D., Vernon
John M. Zivich, M.D., Munster □

C. Dyke Egnatz, M.D., takes office as president of the ISMA



C. Dyke Egnatz, M.D.

C. Dyke Egnatz, M.D., a Schererville family physician, took office as president of the Indiana State Medical Association Nov. 9 at its 142nd annual meeting held at the Westin Hotel in Indianapolis.

Dr. Egnatz, a native of Hammond, Ind., is a member of the American Academy of Family Physicians and is certified by the American Board of Family Practice. He is on the staffs of St. An-

thony Hospital, Munster Community Hospital, St. Margaret Hospital and Our Lady of Mercy Hospital.

A 1960 graduate of the Indiana University School of Medicine, Dr. Egnatz has served the ISMA as speaker, vice-speaker and 10th district trustee. He is a member of the board of directors of Physicians Insurance Company of Indiana and the Indiana Foundation for Medical Care in Fort Wayne. □

William H. Beeson, M.D., chosen ISMA president-elect

William H. Beeson, M.D., an Indianapolis facial plastic and reconstructive surgeon, was chosen president-elect of the Indiana State Medical Association (ISMA) during the ISMA 142nd annual convention.

A 1976 graduate of the Indiana University School of Medicine, Dr. Beeson has served the ISMA as speaker and vice-speaker of the House of Delegates and as a board member. He is secretary of the American Academy of Facial Plastic and Reconstructive Surgery and treasurer of the

American Academy of Cosmetic Surgery.

Dr. Beeson, a native of Knox, is board-certified with the American Board of Otolaryngology, the American Board of Cosmetic Surgery and the American Board of Facial Plastic & Reconstructive Surgery.

He is a past president of the Marion County Medical Society, the Indiana University School of Medicine Alumni Association and the Indianapolis Entrepreneurship Academy. He also is a board member of the American Cancer Society, Marion County Chapter. □



William H. Beeson, M.D.

Address of the president, Michael O. Mellinger, M.D.

Mr. Speaker, officers, trustees and delegates, guests, medicine today is at a crossroads. Although all segments of society have been affected by the information revolution, no profession has been more profoundly affected than has medicine. Medicine today in Indiana and nationally is at a crossroads and going back is not an option. Twenty-six years ago when I entered private practice, doctors had the information needed to provide health care. Patients came to us for care based on information we had exclusively.

Now, significant research results are on the evening news before they are published in medical journals. There is a PDR or its equivalent in most American homes. The lay press is replete with theories of carcinogenesis on everything from diet to drinking water - some of it factual, much of it not.

The result of this is that the physician no longer has exclusive access to medical information and consequently the doctor-patient relationship is evolving and changing.

People today, if anything, suffer from too much information, some of which is fallacious. They need physicians, more than ever, to sort out what is important for them, personally. The information revolution which affects all of us so profoundly is nothing more than the improved ability to collect, store and disseminate information. There is no guarantee that that information will be significant or even true, for that matter.

However, I am convinced that the future of medicine (as well as many other segments of society)

will depend, to a large extent, on how well we adapt to and use this revolutionary change in our ability to communicate.

Change, although always uncomfortable, is inherently neither good nor bad. How we react to and use change is what determines the final result.

Patients come to us today armed with more information (be it true or false) than ever before. They don't want to manage their own health care. If they did, they wouldn't come at all. But most patients today want to be a partner in their health care decisions - they want to know their options and relative risks of doing something as opposed to doing nothing.

Medicine works best when a free flow of information in both directions results in action from both the doctor and the patient. Certain decisions can be made only by the patients - like lifestyle choices regarding smoking, drugs or alcohol abuse and other destructive behavior. Those choices must be made based on factual information as to what medicine can and cannot do. For best results, the patient must take some responsibilities for his or her own health.

In the minds of many people today, high-tech equals high cure. They think with all the miracles of modern medicine that if everything doesn't always go perfectly that someone must have done something wrong.

We run into problems in medicine when patient expectations and medical results fail to coincide. But if the public expects medicine to fix the results of a lifetime of unhealthy behavior, they need to understand that we can't do that.

There is some other information the public is not getting. They need to know that advancing technology and the aging American population are the primary forces escalating health care costs.

There will be no quick fix. We (society, not just doctors) are going to have to take a long, hard look at allocation of health care dollars to make a difference.

And unless the public wants health care delivered with all the compassion of the IRS and the sensitivity and efficiency of the United States Postal Service, a single payor national health care program based on planned scarcity just will not work.

I do believe, however, if we are to avoid a hastily drawn, poorly thought out single payor system we have, at most, a very few years to act. Public opinion is rapidly approaching a critical mass, that when reached, will demand action of the "do something, even if it's wrong" variety.

We can use the information revolution to forge a closer doctor-patient alliance with common goals.

We must aggressively oppose any further incursions into the doctor-patient relationship by the top-heavy bureaucracy whose main goal is to justify its own existence. We need to talk candidly about such topics as professional liability. Let's face it, we live in a country where a 14-year-old can sue Toys R Us and Nintendo because he has a carpal tunnel syndrome. We live in a country where, when an impaired school bus driver has an accident, Navistar is sued for having the brake pedal too close to the accelerator.

And we live in a country

where often it is the best doctors who are sued, not because they have done anything wrong, but because they accept the toughest cases - the ones most likely to go wrong.

We have reached that time when being sued is not a disgrace; it's abuse of the tort system that's a disgrace.

We need to use the doctor-patient relationship to disseminate factual information to our patients. We need to train our staffs and take the time ourselves to talk to our patients and tell them what's going on.

The future of free choice medicine lies in this doctor-patient partnership and if it fails, we have nothing to offer but technology.

We need to let them know how INCAP, the Indiana Compensation Act for Patients, works on their behalf.

Since the passage of INCAP in 1975, the doctor drain out of Indiana has stopped. The physician-population of Indiana has increased 107 percent in that interval, while the general population of Indiana has increased 4.6 percent. While we are still well under the national physician to population ratio, at least in Indiana patients do not have to drive 50 to 75 miles to find obstetrical care like they do in many surrounding states.

INCAP has balanced access to quality medical care with fair compensation for patients who are injured, and at the same time, has created a stable practice environment for doctors.

An hour-long presentation on INCAP is scheduled for 2 p.m. on Saturday. I urge you to attend to learn more about INCAP and what it has meant for patients and physicians in Indiana.

Perhaps one drawback of all the information available to patients is that it adds to their confusion about how to gauge a doctor's competence. We should tell them that membership in medical societies, in specialty academics and board certification are indicators of a doctor's competence.

We must tell our patients that we are concerned about quality of care but that we as individuals and as a medical society have no power to discipline doctors. Discipline is within the purview of the Medical Licensing Board, and we support funding that will allow it to function more efficiently. The ISMA cooperates with the Medical Licensing Board at every opportunity.

Our patients also deserve to be treated with respect and compassion. We have reached a time when we can no longer afford rudeness to patients by anyone associated with providing care. I think this extends beyond our office to the hospital setting. We are perceived as a team and are perceived as uncaring if even our hospital clerks are allowed to be rude.

One of the ways we as a state medical society can help our members better communicate with patients is by taking the lead in risk management. Physicians Insurance Company of Indiana has laid the early groundwork and stands ready to act as a partner. A risk management program by ISMA serves a dual purpose: First, it provides an important membership service by disseminating vital information to our members regarding current trends in litigation, and second, it sends a message that ISMA is concerned about quality of care.

Another issue that has weighed on all our minds lately is the resource-based relative value scale.

I'd like to commend those of you who took action on HCFA's proposed across-the-board cut of 16 percent upon implementation of the RBRVS. Here is an example of how aggressive leadership, on both the state and national levels, combined with grassroots involvement by the membership can make a difference.

There will be little time to savor victories, however, because many other tougher issues are on the horizon. Never has a strong, cohesive, action-oriented medical society been so important to all of us.

I'd like to close with a few words about leadership. Abigail Adams once wrote the following to Thomas Jefferson, "These are the hard times in which a genius would wish to live ... Great necessity calls forth great leaders."

Medicine will produce great leaders in the coming decade. Many of you here this morning will find yourselves in a position that through effort and vision you can take action that will make a difference for your colleagues and your patients.

Leadership is not something you can successfully aspire to ... it's like being happy - it just happens ... and much of the time you're not even sure why.

My favorite definition of leadership is by Herman Miller, CEO, Max DePree. I quote, "The first responsibility of a leader is to define reality. The last is to say thank you. In between the leader is a servant." Last year and this year at this meeting and the interval in between, I've tried to define

the reality of medicine not as it is - we all know that, but reality as it threatens to become and conversely as it can be in the future.

I have served this past year within the limits of my ability. Some of you could have done it better ... no one will ever try

harder. And that brings us to the last thing. Thank you all for allowing me the privilege and pleasure of serving as your president. □

Address of the president-elect, C. Dyke Egnatz, M.D.

The Minute Men had more time.

The mirror mirror on the wall is cracking and the image of the physician is becoming a fleeting glimpse.

I wrote that in 1985; but the urgency remains the same in 1991. Therefore, we must continue to heighten our response as the shot clock winds down.

As a profession, our response must reflect pride, not apology. Medical care and medical service in America has star wars technology. The capabilities of medical science are exceeding imagination. Our outcomes are often limited only by the awareness level of our patients and their timing in entering the American health care system. In addition to crisis intervention, our patients must be educated on health and wellness guidelines.

Until our government can clone our citizens into look-alikes and legislate the distribution of disease, trauma, and tragedy, stories of sad and heartbreaking medical cases will continue.

Health care has gone from the two-dimensional fraction of the doctor and the patient to the three-dimensional isosceles triangle of medical care provider, patient consumer and third-party financial broker.

The American Academy of Family Practice describes the in-

teraction of the medical service components as a triangle with cost, access and quality as its legs. By definition, this triangle cannot be altered in an equilateral fashion. Any two of the legs can be maximized at the expense of the third.

If cost and access are unlimited, quality must yield.

If cost and quality are unlimited, access must yield.

If access and quality are maximized, cost must yield.

These are the realities of society, not the fault of medicine and physicians. The demands and expectations for health and wellness have been skewed by special interest and non-special interest components of our society.

A further listing of the problems which exist in our complex society could be endless. It is more important to focus on the issues we can address in serving our membership and ultimately our patients.

If we as physicians have undertaken a leadership position for the responsibility of health care services, then we must offer solutions which balance the practical components of the cost-access-quality triangle with the high technology of our training which is only limited by our imagination and integrity.

Unless society decides to support medicine in its own behalf,

budgetary and distribution schemes will be under the control of the payers of medical care. Medical treatment and medical care recommendations must be determined by multi-factorial criteria controlled by physicians, balancing the responsibility for payment between the patient and the third-party negotiator.

However, a further factor which wrinkles the idealistic triangle is the influence of professional liability risk and the excess utilization performed or demanded in the name of risk management and defensive medicine.

My hope for contribution to this on-going passing parade of our society is to challenge every physician in Indiana to perform his or her professional and humanitarian best in making medical care judgments and recommendations to his/her patients. With such grassroots strength, ISMA can focus its efforts to supply you with the support tools to accomplish your career goals.

First, medical education

- Support the medical school in training and acquiring new physicians.

- Actively campaign the legislature for continuation and enhancement of the regional medical campus program.

- Continue support and participation in residency programs throughout the state.

- Coordinate CME programs and workshops for practicing physicians in the state.

These issues must be supported to guarantee quality physician training and meet future manpower needs.

Professional liability

- Understand INCAP, the Indiana Compensation Act for Patients.

- Communicate the concern of yourself and ISMA regarding professional liability to your patients and your community.

- Promote the health care cost-saving effect of our Indiana law.

- Maintain awareness of the cost-saving programs of PICI.

- Remain alert to self-serving challenges to our professional liability laws by outside interests.

The impact of liability costs must be conveyed and shared with our society.

Physician quality assurance

- Continue coordination with the Indiana State Medical Licensing Board regarding criteria for licensing, renewal and discipline.

- Continue support to the AMA challenges of the National Practitioner Data Bank.

- Support the Commission on Physician Assistance to continue the voluntary monitoring of physicians in need of help.

- Support appropriate drug monitoring utilization programs.

- Continue interaction with PRO groups to comply with regulations.

- Continue educational and informational services to our members regarding laws and regulations that affect medical practice.

- Maintain informational re-

sources of credentialing issues to assist medical staffs in monitoring membership.

Remember, in dealing with the administrative requirements which impact our work, an informed physician is a much more secure physician.

Legislation

- Further enhance the implementation and utilization of our key contact legislative program.

- Support legislative and membership activities of the ISMA Auxiliary.

- Promote IMPAC/AMPAC participation.

- Maintain visibility and communications with state and national legislators.

- Continue support of the Indiana University Regional Campus Program.

- Coordinate realistic regulations regarding AIDS testing and management.

- Continue participation and monitoring of the Governor's Health Policy Commission.

- Support equitable and affordable Medicaid.

Your on-going study of legislative action goes beyond physician interest. It is the conduit that reaches every citizen in Indiana regarding their health care and their response as a voter.

Medicare/Medicaid

- Continue dialogue with Medicare/Medicaid on behalf of physicians and patients.

- Distribute timely educational material on RBRVS implementation.

- Explore the concept of allowing Medicare-eligible patients with the interest and ability to pay, to opt out of Medicare for

desired non-reimbursable services. Such opportunities may make Medicare service for the needy more cost effective for our nation as a whole.

These topics of challenge are fundamental to our existence for the common goal of patient protection:

1. Education
2. Liability
3. Quality Control
4. Legislative Impact
5. Utilization

There are many other issues which are specific examples and will be addressed in context with the needs and interests of our membership and our society.

These include:

1. HIV testing, monitoring and reporting.
2. Managed care programs.
3. Physician and staff training programs.
4. RBRVS implementation.
5. Physician rights.
6. Patient rights.
7. Media communication.
8. Practice parameters.
9. Hospital medical staff section of AMA.

Another topic I would like to comment on is the Patient Self-Determination Act of 1990, due for implementation next month. The act requires hospitals and nursing homes to tell patients about the patient's right to make decisions about medical care. Prior to treatment, hospitals and nursing homes are required to inform patients about advance directives including living will and durable powers of attorney for health care. You need to be aware of those requirements so you can assist your patients, hospitals and nursing homes.

Therefore, you must each take

the time to understand your responsibility and liability in the Patient Self-Determination Act of 1990.

Other ethical issues you need to be aware of include Code Blue, DNR, and right to die controversies. An expansion of the right to die issue was a referendum on the ballot in the state of Washington

for physician-assisted death legislation. That outcome may have national impact.

Something that definitely will have national impact are practice parameters.

In some ways, it is the development of practice parameters in which only the patient, not the doctor, has the option to vary the

therapy. These are challenging social, moral and practical issues for everyone's future.

In closing, I would like to quote a famous American, Smokey the Bear, who said, "Remember, only you can prevent forest fires."

Thank you. □

Address of the ISMA Auxiliary president, Kay Enderle

It is my pleasure to represent the Indiana State Medical Association Auxiliary as their president this year and to report to you about the auxiliary and its activities.

We have set goals for membership this year of a 10% increase. We will work on the retention of members and the recruitment of new members. For those counties who wish to participate, the ISMA-A has billed all their potential members. They were billed and will be sent out a reminder and then a delinquent notice. We will bill all spouses of physicians in unorganized areas in the hope they will join as members at-large. We hope this billing procedure will aid in increasing our total membership.

Our state health project for the year is breast health. We will sponsor a seminar tomorrow for all spouses on Breast Health - Ask the Experts. We will have a guest speaker, Ms. Linda Smart from the National Cancer Institute, and a panel discussion of physicians with a question-and-answer session. The physicians participating are: Dr. David Price, a general surgeon from Indianapolis; Dr. John Pulcini, a plastic surgeon

from Evansville; Dr. Susan Rogers, a pathologist from Marion; and Dr. Jonathon Stafford from Bloomington. We also are asking all auxiliaries to pledge to have a breast exam and mammogram and to take a friend to have an exam as well. They are to return their pledge card to our ISMA-A health chairman. We will then tally and publish our responses.

We will continue to sponsor activities to raise funds for AMA-ERF to aid in the education of tomorrow's physicians. The Indiana auxiliaries raised \$35,000 for AMA-ERF last year. We hope to raise at least this amount this year. We to date have sponsored two very productive seminars and will have two more this year. They are open to all auxiliaries.

Our members continue their projects for the promotion of better health care in their communities. Projects range from raffling a newly built home, a car and a vacation, to sponsoring a course for baby sitters on first aid, to delivering meals on wheels. They work in coalition with other agencies and raise funds for scholarships and funds for free health clinics and drive vans which give rides for people to their doctor

appointments.

We are working hard to improve our public image. We have had a meeting on how to work with the media. It is our hope to get more positive publicity published.

We hope to work with our county medical societies more efficiently and to increase our communication with them. We would like to have more joint meetings with our spouses. Legislation is still paramount, and many county auxiliaries have had legislators visit and speak at their meetings. We will again sponsor the Day at the Capitol in February. We will write letters to our legislators after our briefing from the legislative staff from the ISMA. We will then deliver these letters to our legislators at their offices in the capitol.

The Indiana State Medical Association Auxiliary commitment remains strong and we will continue to renew our commitment to our organization. We are a unique group; we are all spouses of physicians and are proud to aid our spouses in the promotion of better health care in the state of Indiana. Thank you for the opportunity to report about our auxiliary. □

■ annual reports

THIRD DISTRICT

Gordon L. Gutmann, M.D.

The ISMA Third District held its annual meeting May 15 at the Islands Restaurant. The meeting was well-attended by officers from the component counties who spoke on various issues troubling the counties. In particular, the inability to attract new primary care physicians, as well as some specialties, was of greatest concern. Also, in our part of the state, managed care plans are numerous and confusing and have been most difficult to deal with. Steve Havens, M.D., of Jeffersonville was elected Third District president, and I was re-elected Third District trustee for a second term.

One resolution regarding cigarette warning labels, submitted by Dick Huber, was endorsed by the district. Two quarterly district meetings already have been held, giving me an opportunity to exchange information with the county societies. During the last quarterly meeting, we reviewed all of the resolutions to prepare for the ISMA annual meeting.

COMMISSION ON LEGISLATION

Eugene Roach, M.D., chairman

The 1991 session of the Indiana General Assembly kept Indiana physicians busy. The make-up of the legislature brought new dynamics to the process: The House of Representatives was led by the Democratic party and the Senate by the Republicans. With reapportionment of legislative districts and tough budget decisions, legislators were unable to complete their work by the statu-

tory deadlines, so two separate special sessions were called by the governor. After months of bickering, legislators finally completed their work and returned home June 14.

As always, the 1991 session handed organized medicine a mixed bag. Some of the significant legislation that passed is listed below:

- * HEA 1731 – requires rather than allows the state board of health to conduct contact tracing activities when they are notified under the “duty to warn” statute.

- * HEA 1732 – clarifies that a local health department operates as an agency of local government.

- * SEA 30 – requires the department of public welfare to seek approval to change the Medicaid plan to allow the waiver of parental income and resources for children who are eligible for Medicaid and who are at risk of being institutionalized.

- * SEA 281 – allows optometrists to prescribe legend drugs.

- * SEA 295 – requires insurers to offer to provide coverage for breast cancer screening mammography.

- * SEA 617 – reorganizes health and human services programs by reorganizing the department of public welfare, department of mental health and department of human services. Renames the state board of health the department of health.

A partial list of bills that did not become law is listed below:

- * HB 1131 – would have allowed people to specify that they would like nutrition and hydration removed in the event they become terminally ill.

- * HB 1348 – would have prohibited corporal punishment in public schools.

- * HB 1613 – would have allowed a physician to test a patient for HIV without the patient’s informed consent.

- * HB 1824 – would have fined physicians \$10,000 per day, disciplined a medical license and assigned a criminal penalty to physicians who refuse to treat patients who are HIV-positive or who are perceived to be HIV-positive.

- * HB 1898 – would have created a Canadian-style universal health system in Indiana.

- * SB 166 – would have reduced the legal blood alcohol limit to .08%.

- * SB 257 – would have applied prejudgment interest to awards from the Patients Compensation Fund.

- * SB 404 – would have certified professional counselors to diagnose and treat mental disorders.

The ISMA followed hundreds of bills that were introduced. The Commission on Legislation met four times to review the bills and their impact on the practice of medicine.

After the session adjourned, ISMA staff compiled the 1991 *Digest of Health and Medical Laws*. To obtain a free copy, call the ISMA Department of Government Relations at (317) 261-2060 or 1-800-969-7545.

The 1991 session was the “maiden voyage” for the ISMA’s new peer-to-peer telephone tree. Under this program, physicians are alerted to the need for grassroots action and are expected to call their legislators and two other physicians who will respond likewise. The telephone tree was established in response to a resolution from the ISMA House of Delegates, and it worked well this

year. We must all participate in this program and respond quickly and accurately when contacted.

Once again, the Physician of the Day program was a success during the General Assembly. Several physicians agreed to participate, and each found the program to be rewarding. John Records, M.D., was featured as a Physician of the Day in *The Indianapolis Star*.

I would like to express my gratitude to the physicians who served on the Commission on Legislation and took time out of their busy schedules to attend the meetings. Their commitment to the commission benefits organized medicine.

COMMISSION ON MEDICAL SERVICES

Susan Pyle, M.D.

The Commission on Medical Services met Feb. 13. At the meeting, members discussed whether the ISMA should continue to endorse vendors and, if so, what kind of restrictions should be developed. Members voted to recommend that the ISMA discontinue endorsing automobile dealerships. The cost in administrative time was great, and there was little return for the membership in exchange for the costs.

The commission discussed the efficacy of the ISMA being involved in endorsements. The

commission decided that members did not have enough expertise to judge many products. Therefore, the commission decided that the ISMA should stop endorsing products, except the travel agency and bank card.

Commission members also voted to recommend that future mailings from ISMA-endorsed members not be mailed in ISMA stationery because it was mistaken for official ISMA business.

We were disappointed to learn that Dallas Coate, M.D., was leaving the state to complete a fellowship in Texas. His service to the Commission on Medical Services is appreciated by its members. □

Scientific exhibit winners

First place

"Differential and specific labeling of epithelial and vascular endothelial cells of the rat lung by *Lycopersicon esculentum* and *Griffonia simplicifolia* I lectins."

Exhibitor: Glyn A. Porter, Ph.D., Northwest Center for Medical Education, Indiana University School of Medicine, Gary.

In the rat lung, *Lycopersicon esculentum* (LEA) lectin specifically binds to the epithelium lining bronchioles and alveoli whereas *Griffonia simplicifolia* I (GS-I) lectin binds to the endothelium lining alveolar capillaries. In this study, the lectins LEA and GS-I were used to assess the presence of differentially expressed endothelial or epithelial glycoproteins in the rat lung. The specific binding affinity of the lectins was examined on semi-thin (0.5 μ m) and

thin (<0.1 μ m) frozen sections of lavaged rat lung. The sections were incubated with biotinylated LEA (bLEA) or GS-I (bGS-I) followed by streptavidin conjugated to Texas Red (for semi-thin sections) or to 5 nm colloidal gold (for thin sections). On semi-thin frozen sections, LEA bound to epithelial cells lining bronchioles and the alveoli (Type I but not Type II epithelial cells). On thin frozen sections, bLEA-streptavidin-gold conjugates were confined primarily to the luminal plasmalemma of Type I cells. bGS-I-streptavidin-Texas Red was detected on the endothelial cells of alveolar capillaries but not on those of arterioles, venules or larger vessels. Ultrastructurally, GS-I-gold complexes were localized primarily to the luminal plasmalemma of thick and thin regions of the capillary endothelium

with a higher affinity to plasmalemmal vesicles and their introits in the thick region. While neither lectin labeled Type II alveolar cells, both labeled macrophages in the interstitia and in incompletely lavaged alveoli. This differential and specific labeling should allow for the direct isolation of endothelial glycoproteins and the subsequent generation of antibodies for future studies on the blood-air barrier. □

Second place

"Dissociation of human erythrocyte spectrin dimer into monomers under non-denaturing conditions."

Exhibitor: Scott Hollingsworth and Tom Mueller, Northwest Center for Medical Education, Indiana University School of Medicine, Gary.

The red cell membrane skeleton is a network of peripheral proteins, which lines the cytoplasmic aspect of the membrane bilayer and is involved in controlling red cell shape and deformability characteristics. The skeleton is classically derived by extracting membranes with the nonionic detergent Triton X-100 at 4° C. Obviously, however, 4° is not physiological. Thus, the question of the relevance of the skeletal composition at 4° to physiological temperatures is open. This study explored the composition of the membrane skeleton at physiologic temperatures. By varying the ionic strength of the nonionic detergent solution, it was possible to obtain skeletal residues at 37° C with both Triton X-100 and octyl-glucopyranoside. Furthermore, while exploring this question it was observed that the spectrin dimer dissociates under certain extraction conditions.

Spectrin is the dominant protein of the membrane skeleton, and it contains two subunits with

apparent molecular weights (Mr) on sodium dodecyl sulfate (SDS) gels of 260,000 (alpha) and 225,000 (beta). Previously, the spectrin dimer has been reported to dissociate only under strongly denaturing conditions, e.g., in the presence of high concentrations of urea or SDS, or at high temperatures. When red cell stroma were incubated with six volumes of 40 mM octyl-glucopyranoside and 0.45-0.90 M NaCl at 37° C and then centrifuged, it was observed that the alpha subunit of spectrin was approximately 80% solubilized while most of the beta subunit remained with the pellet. These results suggest that the spectrin subunit interactions are not as strong at physiologic temperature as was previously inferred from studies done at 4° C. □

Third place

"Electrophoretic identification of mutation."

Exhibitor: Patricia G. Wheeler, Indiana University

Medical Center, Indianapolis.

Polymerase chain reaction (PCR) amplification and denaturing gradient gel electrophoretic (DGGE) analysis of adenine phosphoribosyltransferase (APRT) genes has been evaluated as a method of screening for single base pair mutation. Previous work had demonstrated that plasmids containing mutated APRT genes could be distinguished by DGGE. In this study, primers were designed for PCR and used to amplify mouse APRT genes. PCR amplification was successful for both plasmid and genomic DNAs. Known and induced single-base substitutions could be distinguished using amplified DNA. Another method of determining single base pair mutations, single strand conformational polymorphism (SSCP), was also investigated. This method works by running single stranded DNA instead of double stranded DNA on a non-gradient acrylamide gel. □

RESOLUTION 91-1 Insurance Premium Increases
 Introduced by: Lake County Medical Society
 Referred to: Reference Committee 4
 Action: Referred to the ISMA Board of Trustees

Whereas, The health insurance for our members sponsored by the ISMA has been providing a multitude of optional plans for our members; and
 Whereas, The annual premium increases have been rising sharply in the past few years; and
 Whereas, There have been disproportionately high increases to a few plans compared to the amounts of monies expended by the plan; and
 Whereas, The ISMA Subcommittee on Insurance has been reporting to the ISMA Board of Trustees too late for the Board to take different action; therefore be it
 RESOLVED, That the Subcommittee present to the ISMA Board its recommendation for fee changes several months in advance so that the Board will have ample time to consider alternate plans and programs.

RESOLUTION 91-2 Dues Payments on Installment
 Introduced by: Steven M. Yoder, M.D., Goshen
 Referred to: Reference Committee 4
 Action: Not Adopted

Whereas, It is becoming increasingly important that physicians have a strong voice to the public, government, third party payers, etc.; and
 Whereas, Increased membership in ISMA and AMA will help achieve this goal; and
 Whereas, Most physicians belong to at least one specialty association whose dues are also increasing; and
 Whereas, These assessments seem to come due at the same time of the year;
 Whereas, This may have the effect of limiting membership in both ISMA and AMA; therefore, be it
 RESOLVED, That ISMA establish a payment plan to spread the dues expense over a longer period of time.

RESOLUTION 91-3 Health Insurance Experience
 Introduced by: Lake County Medical Society
 Referred to: Reference Committee 4
 Action: Referred to the ISMA Board of Trustees

Whereas, Health insurance costs rise yearly; and
 Whereas, ISMA offers through its insurance several options; and
 Whereas, Options are presumably offered for the purpose of individuals selecting the risk they wish to assume; and
 Whereas, In the past, premiums for all options have increased by a uniform percentage reflecting the amount needed to cover all programs rather than to reflect experience of individual options; and
 Whereas, Such across-the-board increases require those assuming higher deductible risks to subsidize those of other lower deductible and higher experience rate plans; therefore be it
 RESOLVED, That all ISMA options maintain premiums commensurate with the experience of that option.

RESOLUTION 91-4 Addition to Cigarette-Package Warning
 Introduced by: Third District Medical Society
 Referred to: Reference Committee 4
 Action: Adopted as Amended

Whereas, There is growing evidence that exposure to passive smoking is harmful; and
 Whereas, Such evidence indicates that infants, children and adolescents exposed to passive smoking in the home have higher incidences of respiratory infections, delayed maturity of pulmonary functions, and risks of lung cancer in adulthood; and
 Whereas, Infants, children, and adolescents are usually unable to avoid or cause a change in their exposure to passive smoke in the home; therefore be it
 RESOLVED, That the Indiana State Medical Association seek through the American Medical Association federal legislation requiring all cigarette packages sold in the United States to contain a warning label that unborn children, infants, and adolescents living in a home with smokers are more likely to develop respiratory infections and lung cancer.

■ resolutions

RESOLUTION 91-5

Commission on Medical Economics

Introduced by: Fifth District Medical Society
 Referred to: Reference Committee 4
 Action: Referred to the ISMA Board of Trustees for further study and report back to the 1992 House of Delegates

Whereas, There is increasing concern about the escalating cost of health care with all intent outright to invite further federal intervention; therefore be it

RESOLVED, That Indiana State Medical Association establish a commission of medical economics to:
 1) study and recommend solutions to increasing medical costs; and be it further

RESOLVED, That membership should be appointed from each district of the Indiana State Medical Association; and be it further

RESOLVED, That if the commission fails to meet at least semiannually, it should cease to exist.

RESOLUTION 91-6

Educating Physicians in Pertinent Legal Matters

Introduced by: Lawrence County Medical Society
 Referred to: Reference Committee 4
 Action: Adopted

Whereas, Physicians are approached in their professional and personal lives by the law enforcement and the legal systems, with little or no previous experience or education; therefore be it

RESOLVED, That the Indiana State Medical Association present a comprehensive session on "Physicians' Encounters with the Legal and Law Enforcement Systems" via the annual meeting, district meetings or a separately scheduled meeting.

RESOLUTION 91-7A

Prohibit Corporal Punishment in Indiana Schools

Introduced by: John W. Luce, M.D., LaPorte County
 Referred to: Reference Committee 3
 Action: Substitute Resolution 91-7A Adopted

RESOLVED, That the ISMA reaffirm its opposition to corporal punishment in schools and licensed day care provider settings in Indiana; and be it further

RESOLVED, That the ISMA contact and work with the Indiana State Teachers Association regarding ISMA's opposition to corporal punishment in schools; and be it further

RESOLVED, That the ISMA spearhead the petitioning of the state legislature to prohibit corporal punishment in schools and licensed day care provider settings in Indiana.

RESOLUTION 91-8

Timely Distribution of ISMA Resolutions to County Medical Societies

Introduced by: District 5
 Referred to: Reference Committee 2
 Action: Adopted

Whereas, Prior to the 1990 ISMA House of Delegates, many county medical societies did not have access to the resolutions which were to be considered during the 1990 Annual Meeting; and

Whereas, Currently, ISMA Bylaws require that resolutions be submitted at least 45 days prior to the convening of the House of Delegates; and

Whereas, Resolution 90-29, adopted by the 1990 House of Delegates, sets forth guidelines to facilitate better communication between the ISMA and its component county societies; and

Whereas, Failure to receive resolutions by county societies effectively excludes all but the delegates from the opportunity to review and fully consider the matters addressed by the resolutions, and entrusts delegates with having to represent without the benefit of discussion of the views of their county societies; and

Whereas, Current Bylaws are in place to permit resolutions to be submitted of an extreme emergent nature, past the 45-day deadline, and are considered by the Committee on Rules and Order of Business; therefore be it

RESOLVED, That ISMA Bylaws be amended to require that the current deadline for submission of resolutions be extended to 60 days prior to the convening of the ISMA Annual Meeting; and be it further

RESOLVED, That the staff of ISMA be directed to prepare and distribute to all county societies the draft copies of all submitted resolutions no later than 45 days prior to the ISMA Annual Meeting.

RESOLUTION 91-9 Triplicate Prescriptions
 Introduced by: Fountain-Warren Medical Society
 Referred to: Reference Committee 3
 Action: Adopted

Whereas, The triplicate prescription law has been in effect several years; and

Whereas, The purposes of passing such legislation were specific; and

Whereas, Several state medical societies are contesting the validity of those purposes; and

Whereas, No information has been circulated to the health professionals in our state regarding the success of such prescribing; now therefore be it

RESOLVED, That ISMA request a complete and in-depth report from all agencies and governmental departments who are involved in all aspects of triplicate prescription writing in Indiana, within 90 days of adoption of this resolution by the House of Delegates.

RESOLUTION 91-10A PRO Committee
 Introduced by: Lake County Medical Society
 Referred to: Reference Committee 3
 Action: Substitute Resolution 91-10A Adopted

RESOLVED, That the ISMA PRO Liaison Committee compile data on judgments made by the PRO and disseminate that information to county medical societies.

RESOLUTION 91-11 ISMA Commission on Medical Services
 Introduced by: ISMA Executive Committee
 Referred to: Reference Committee 2
 Action: Referred to the ISMA Board of Trustees for further study and report back to the 1992 House of Delegates

Whereas, The ISMA Commission on Medical Services is a commission created by the ISMA Constitution and Bylaws; and

Whereas, The ISMA Constitution and Bylaws calls upon the Commission on Medical Services to "concern itself and assume special responsibility in obtaining information and giving counsel and advice to the Association with respect to all matters in which medical service comes into contact with any existing or

proposed functions of government, including civil defense, rehabilitation of persons handicapped by abnormality or disease, medical service in welfare departments, maternal and child health programs sponsored through governmental agencies, medical care of military personnel, plans and programs for medical care of veterans, medical care for dependents of those in uniformed services of the government, plans and programs of the government for medical care now existing or which heretofore may be adopted by any special group, government programs for elimination of sexually transmitted diseases and other communicable diseases, and all programs and plans for medical care to be provided through municipal, state or federal governments;" and

Whereas, These policy areas are addressed by the Commission on Legislation and other ad hoc committees established to serve specific purposes; and

Whereas, It is important that ISMA, as an organization led by busy volunteers, must continue to strive to make the best and most efficient use of those members' time who generously agree to serve on commissions and committees; now therefore be it

RESOLVED, That Section 7.1008 of ISMA's Constitution and Bylaws be deleted to reflect the elimination of the Commission on Medical Services.

RESOLUTION 91-12 Primary Health Care - I.U. Regional Centers
 Introduced by: Section on Family Practice
 Referred to: Reference Committee 3
 Action: Refer to Resolution 91-28, Adopted in lieu of Resolutions 91-12 and 91-18

RESOLUTION 91-13A Utilization Review/Managed Care
 Introduced by: John Yarling, M.D., Muncie
 Referred to: Reference Committee 3
 Action: Substitute Resolution 91-13A Adopted as Amended in lieu of Resolutions 91-13 and 91-24

RESOLVED, That the Indiana State Medical Association support legislation requiring that the activities of managed care organizations be under the purview of the Medical Licensing Board and that they thereby become subject to the same legal constraints as other practitioners; and be it further

RESOLVED, That the Indiana State Medical Asso-

■ resolutions

ciation seek legislation to give authority to the Medical Licensing Board to review and oversee the utilization review/managed care entities in the State of Indiana.

RESOLUTION 91-14 The AMA "Principles of Medical Ethics"

Introduced by: Wayne-Union County Medical Society
Referred to: Reference Committee 2
Action: Adopted as Amended

Whereas, There is an increasing number of people who no longer have adequate insurance, reducing their ability to pay for the cost of present-day care; and

Whereas, There is continued attack on the image of the medical profession; therefore be it

RESOLVED, That the ISMA Delegates to the AMA House of Delegates seek to amend "The Principles of Medical Ethics" as follows:

a) That Principle (I) be amended to read, "A physician shall be dedicated to providing competent medical service for all people."

b) That Principle (VI) be amended to read, "A physician shall, in the provision of appropriate patient care except in emergencies, be free to choose whom to serve (providing he knows such care is otherwise available and can so advise if indicated), with whom to associate and the environment in which to provide medical services."

RESOLUTION 91-15 Reorganization of ISMA Trustee Districts

Introduced by: Wayne-Union County Medical Society
Referred to: Reference Committee 2
Action: Not adopted

Whereas, There is need for a more effective voice by organized medicine in the establishment of public policy concerning medical care throughout the country; and

Whereas, This policy involves the setting of priorities in local, state, and national levels; and

Whereas, The average member's direct contact with organized medicine is with his/her local county society; and

Whereas, There is a need to increase not only information concerning local and state matters to each

individual member, but to receive their comments on shaping formal local, state, and national policy; and

Whereas, There has been no reorganization of the trustee districts since 1974; now therefore be it

RESOLVED, By the ISMA House of Delegates that the Commission on Constitution and Bylaws take up the question of reorganizing the trustee districts; and be it further

RESOLVED, That the question of reorganization is to include but not to be limited to:

- changing the geographical organization of each district as to reflect common interests and present-day medical referral patterns;

- to removing the offices of president, secretary, and treasurer of the districts and giving these responsibilities to the trustee and alternate trustee; and

- to support and establish periodic meetings between the trustees and the officers of their respective counties.

RESOLUTION 91-16 Safety of Young Children

Introduced by: Betty J. Campbell, M.D., Terre Haute
Referred to: Reference Committee 3
Action: Referred to the ISMA Board of Trustees for study and report back to the 1992 House of Delegates

Whereas, The safety of young children riding in open-bedded vehicles at high rates of speed has long been an item of concern; and

Whereas, The movement of said children within said moving vehicle adds to the risk of injury, therefore be it

RESOLVED, That the ISMA actively seek legislation that shall provide that no child under six years of age be allowed to ride in the open bed of such vehicles on any public access road or highway; and be it further

RESOLVED, That all children riding in the open bed of such vehicles be restrained in an appropriate child safety restraint device, appropriately installed; and be it further

RESOLVED, That any child under six years of age riding within the standard seating area of said vehicle shall also be in an appropriately utilized child safety restraint device.

RESOLUTION 91-17A HBV/HIV Testing

Introduced by: Stephen D. Tharp, M.D.,
Frankfort
Referred to: Reference Committee 4
Action: Substitute 91-17A Adopted as
Amended

RESOLVED, That ISMA establish the following recommendations for patient care by HIV-infected and HBV-infectious health care workers:

- 1) Health care workers who perform exposure-prone, invasive procedures should know their HBV/HIV status.
- 2) If a health care worker who performs exposure-prone, invasive procedures is HBV-infectious or HIV-infected, that worker should either restrict his or her practice to avoid exposure-prone, invasive procedures or consult an expert review panel for advice on how he or she may need to modify his or her practice.
- 3) HBV-infectious or HIV-infected health care workers who continue to practice exposure-prone, invasive procedures should inform prospective patients of their HBV or HIV status if they intend to perform exposure-prone, invasive procedures.
- 4) That testing patients for HIV be performed as medically indicated without specific patient consent but with general health care consent.

RESOLUTION 91-18 Regional Medical Education Centers

Introduced by: Delaware/Blackford County
Medical Society
Referred to: Reference Committee 3
Action: Refer to Resolution 91-28,
Adopted in lieu of Resolutions
91-12 and 91-18

RESOLUTION 91-19A HIV Testing

Introduced by: Delaware/Blackford County
Medical Society
Referred to: Reference Committee 4
Action: Adopted Substitute Resolution
91-19A in lieu of Resolutions
91-19 and 91-26

RESOLVED, That testing patients for HIV be performed without specific consent but with general health care consent and that the Indiana State Medical Association exert all its diligence and effort to introduce legislation in support of this resolve.

RESOLUTION 91-20 Federal Legislative Issues/ Alerts

Introduced by: Vanderburgh County Medical
Society
Referred to: Reference Committee 3
Action: Referred to the ISMA Board of
Trustees

Whereas, ISMA serves as a link from the AMA to the county medical societies and physicians throughout Indiana; and

Whereas, Changing national health issues profoundly affect Indiana physicians; therefore be it

RESOLVED, That the ISMA be more responsive to changing national health care issues with responsibility for communications, including federal legislative issues, to county societies and physician members with greater urgency.

RESOLUTION 91-21 Non-Member Utilization of COPA

Introduced by: Vanderburgh County Medical
Society
Referred to: Reference Committee 1
Action: Adopted

Whereas, Of the 34 cases handled by the ISMA Commission on Physician Assistance (COPA), 23% of the physicians involved were not ISMA members; and

Whereas, The 1990 funding level of \$120,000 allocated to the COPA for staffing, travel involving interventions, monitoring and advocacy activities on behalf of these physicians; and

Whereas, This funding level is currently paid exclusively by member dues;

Whereas, The existence of COPA benefits all practicing physicians regardless of their ISMA membership status; and

Whereas, It is not the intention to deny access to services to impaired physicians who may not be able to pay for the services provided by COPA; therefore be it

RESOLVED, That ISMA non-members who are participants of the ISMA COPA program be assessed on a pro-rated basis a portion of the costs associated with and incurred by the COPA. This cost may be paid upon contracting or at such time as the impaired physician once again becomes a fully-functional member of the medical community to be determined by the Executive Committee, the Board of Trustees and COPA; and be it further

■ resolutions

RESOLVED, That an exclusion from payment in the form of a hardship exception be incorporated into this policy and exercised at the discretion of the COPA.

RESOLUTION 91-22A Laser Surgery - Medical Degree/License

Introduced by: Fort Wayne Medical Society and 12th District
 Referred to: Reference Committee 3
 Action: Substitute Resolution 91-22A Adopted

RESOLVED, That the Indiana State Medical Association petition the Indiana General Assembly to limit laser surgery to only those practitioners licensed to practice medicine and surgery, dentistry, podiatry and veterinary medicine.

RESOLUTION 91-23 Expansion of SEA 30 to Include Medicaid Eligibility for Significantly Premature Infants

Introduced by: Fort Wayne Medical Society and 12th District
 Referred to: Reference Committee 3
 Action: Referred to the ISMA Board of Trustees for study

Whereas, Children born significantly premature require extended hospitalization and treatment, which often exceeds the benefits covered under health insurance policies purchased by their parents; and

Whereas, The average family income cannot assume the financial burden of large hospital bills, while still providing for other family members; therefore be it

RESOLVED, That the Indiana State Medical Association seek legislation that would exclude parental resources and income when determining eligibility for significantly premature children who require extended hospital care and medical services beyond that which is covered by the family's health insurance plans.

RESOLUTION 91-24 Licensing Requirements for Managed Care Organizations

Introduced by: Fort Wayne Medical Society and 12th District
 Referred to: Reference Committee 3
 Action: Refer to Substitute Resolution 91-13A, Amended and Adopted in lieu of Resolutions 91-13 and 91-24

RESOLUTION 91-25 Tobacco Products - Increased Taxation

Introduced by: Fort Wayne Medical Society and 12th District
 Referred to: Reference Committee 3
 Action: Adopted as amended

Whereas, It is a medical fact that use of tobacco products, primarily cigarettes, increases the risk of heart and pulmonary disease; and

Whereas, The number of deaths from cancer, heart and pulmonary disease due to the use of cigarettes and tobacco products is exceedingly high; and

Whereas, The numbers of individuals who use cigarettes and tobacco products decline when the cost of such products is increased dramatically; therefore be it

RESOLVED, That the Indiana State Medical Association seek legislation to significantly increase the tax on cigarettes and tobacco products and that the revenue generated by the tax increase be allocated to health care projects.

RESOLUTION 91-26 Reaffirmation of Resolution Supporting Testing for Human Immunodeficiency Virus (HIV)

Introduced by: Fort Wayne Medical Society and 12th District
 Referred to: Reference Committee 4
 Action: Refer to Substitute Resolution 91-19A, Adopted in lieu of Resolutions 91-19 and 91-26

RESOLUTION 91-27 Indiana Medicine
 Introduced by: Richard J. Noveroske, M.D.,
 for the Warrick County Medical Society
 Referred to: Reference Committee 1
 Action: Filed

Whereas, The state medical journal for Indiana physicians is of questionable or doubtful value (see attached essay, titled "Indianapolis Medicine"); and
 Whereas, This journal currently costs each active member of the Indiana State Medical Association about \$40 a year in dues; therefore be it
 RESOLVED, That this resolution with copies of "Indianapolis Medicine" be widely distributed and thoroughly discussed at the coming fall meeting of the Indiana State Medical Association.

RESOLUTION 91-28 Support to Continue and Enhance the I.U. Medical School Regional Centers
 Introduced by: C. Dyke Egnatz, M.D.,
 Schererville
 Referred to: Reference Committee 3
 Action: Adopted in lieu of Resolutions 91-12 and 91-18

Whereas, In 1971 the I.U. Medical School and the Indiana legislature created the Regional Medical Campus Plan to affordably and quickly meet the medical manpower shortage; and
 Whereas, The regional campuses have proven to be a source of new primary physicians throughout Indiana; and
 Whereas, The regional medical students have often returned to that Regional Center for residency training; and
 Whereas, The opportunity for physicians to participate in medical school and residency teaching has been another significant factor in attracting new practices to the Regional Campus area; and
 Whereas, In spite of the improved physician recruitment stimulated by this program, a significant shortage of primary care physicians continues to exist; and
 Whereas, Regional Medical Centers have offered economical benefits to medical students to remain in their hometown environment; and
 Whereas, The medical student exposure to the Regional Campus has been a conduit to attract candidates for the local primary care residencies and future

practice location decisions; and
 Whereas, The Regional Campuses have experienced a financial deficit anticipated to be \$2.7 million for 1991; and
 Whereas, The medical school budget and appropriation is necessary to maintain high-quality medical education at all the medical school sites, including the Indianapolis campus; therefore be it
 RESOLVED, That the ISMA and its membership continue to support Regional Medical Campuses through continued personal participation, local legislative contact for adequate funding and patient contact to improve community awareness of the need for adequate State funding in order to ensure high-quality medical education and practitioners to care for Indiana citizens, now and into the future.

RESOLUTION 91-29 Physician Responsibility to ISMA/AMA
 Introduced by: C. Dyke Egnatz, M.D.,
 Schererville
 Referred to: Reference Committee 1
 Action: Referred to the ISMA Board of Trustees

Whereas, Medical school graduates have embarked on a career which involves social services and commitment; and
 Whereas, Postgraduate subspecialization in effect is a delegation of services for the common good of patient care; and
 Whereas, Physician colleagues who actively participate in ISMA/AMA and specialty societies have been delegated the responsibility of leadership in physician citizenship and physician rights/duties; therefore be it
 RESOLVED, That ISMA and its leadership at all levels continue to communicate the need for active participation of all Indiana physicians with ISMA and AMA membership as their expression of support to those acting in their interest.

RESOLUTION 30 Medical Disciplinary Process
 Introduced by: Stephen Tharp, M.D.,
 Frankfort
 Referred to: Reference Committee 3
 Action: Adopted as Amended

Whereas, Citizens and physicians in Indiana want to ensure that Hoosiers have confidence in Indiana

■ resolutions

physicians; and

Whereas, ISMA recognizes that opinions of the medical review panel are valuable and in order to make the most informed decision possible, members of the Medical Licensing Board should be allowed to consider the expert panel's opinion; and

Whereas, Technology and other factors continue to advance the practice of medicine and the standard of care that patients expect from the health care delivery system in the U.S. and therefore even the most competent physician may fail to recognize that there are specific clinical areas in which they would benefit from additional training; and

Whereas, In many areas of Indiana, it would be a great disservice to the community for the Medical Licensing Board to revoke or suspend a physician's practice privileges; and

Whereas, It is perceived that Indiana's process for compensating patients for medical-related injuries is unnecessarily lengthy; and

Whereas, Complaints against physicians are presently investigated by individuals with virtually no medical training, even though the issues are technically sophisticated matters of science rather than points of law; and

Whereas, The general public appears to be concerned that incompetent physicians can move from one area to another to avoid disciplinary action; therefore be it

RESOLVED, That:

a) ISMA seek amendment to current law (IC 25-22.5-1-1) to allow the Medical Licensing Board to consider a medical review panel's decision, but not to use the panel's opinion as the sole basis for disciplinary action.

b) ISMA encourage the Medical Licensing Board to recognize that often revocation or suspension of a physician's privilege to provide health care services to a community is not always in the best interest of public health and safety, and that the Medical Licensing Board should use its authority to require appropriate re-education, retraining and counseling in order to retain the necessary services of providers.

c) ISMA staff analyze the time frame and process by which claims are paid in malpractice cases and report to the Board of Trustees any recommendations that would expedite the process without compromising the integrity of the Act.

d) ISMA seek legislation (IC 25-22.5-1-1) to require the Attorney General to employ a licensed physician to assist in the investigation of complaints against Indiana health care providers.

e) ISMA Board of Trustees should immediately study these and related issues further, and consult with appropriate legal counsel.

Memorial Resolution for Martin J. O'Neill, M.D.

Introduced by: Porter County Medical Society
Action: Adopted by Acclamation

Whereas, Martin J. O'Neill practiced medicine in Indiana for some 45 years;

Whereas, Dr. O'Neill served organized medicine as President of the Porter County Medical Society and the 10th District; and

Whereas, Dr. O'Neill served in the ISMA House of Delegates as delegate, as Trustee, and later as Chairman of the Board of Trustees of the Indiana State Medical Association; and

Whereas, He served as President of the Indiana State Medical Association and as Alternate Delegate to the American Medical Association; and

Whereas, He served as a member of the Indiana Medical Licensing Board; and

Whereas, He dedicated his life to the practice of medicine and to the promotion of the profession of medicine and his advice and nurturing will be sorely missed by organized medicine; therefore be it

RESOLVED, That Martin J. O'Neill be honored and remembered by the House of Delegates for his contribution to the profession of medicine.

Commendation for ISMA Members in Desert Storm

Introduced by: ISMA Board of Trustees
Action: Adopted by Acclamation

Whereas, the ISMA is aware that 21 of its physician members left behind family, friends and medical practices to participate in the defense of liberty and democracy in Operation Desert Storm; and

Whereas, the ISMA appreciates the sacrifices of these physicians; and

Whereas, the names of the physicians are as follows:

Darius Ghazi, M.D., Floyd County
Aftab Chaudhry, M.D., Floyd County
Tom Harris, M.D., Floyd County
John Barbee, M.D., Floyd County
John Habermel, M.D., Floyd County
Eusevio Kho, M.D., Scott County
Francis J. Kelly, M.D., DuBois County

John Mahon, M.D., St. Joseph County
 Richard Boersma, M.D., Shelby-Rush County
 Ronald G. Blankenbaker, M.D., Marion County
 Henry Olivier, M.D., Marion County
 Henry G. Stein, M.D., Marion County
 Warrick L. Barrett, M.D., Marion County
 Alan H. Johnson, M.D., Vanderburgh County
 David J. Carlson, M.D., Vanderburgh County
 Gerhard Grieser, M.D., Vanderburgh County

Schuyler Geller, M.D., Vigo County
 Olegario J. Ignacio, M.D., Clark County
 Richard A. Hoefer, M.D., Clark County
 Marc S. Zipper, M.D., Hamilton County
 Carl R. Boyd, M.D., Cass County

RESOLVED, that during the ISMA Annual Meeting, Nov. 10, 1991, the ISMA honors its veterans of Operation Desert Storm. □

Reference Committee members

Reference Committee 1

Reports of Officers and ISMA/AMA matters

Susan Pyle, M.D., Union City, chairman
 James Daggy, M.D., Richmond
 William Vaughn, M.D., Vincennes
 Bernard Emkes, M.D., Indianapolis
 Dennis Egnatz, M.D., Elkhart

Reference Committee 2

Constitution and Bylaws

Charles Aust Sr., M.D., Fort Wayne, chairman
 John Luce, M.D., Michigan City
 Charles Hachmeister, M.D., Evansville
 Laurence Musselman, M.D., Marion
 Patricia Hendershot, M.D., Indianapolis

Reference Committee 3

Legislation and Insurance

Richard Reedy, M.D., Yorktown, chairman
 Jamie Street, M.D., Indianapolis
 Roland Kohr, M.D., Terre Haute
 M. Nabil Shabeeb, M.D., Munster
 Eugene Senseny, M.D., Roanoke

Reference Committee 4

Member Services and Public Health

Frank Johnson, M.D., Indianapolis, chairman
 Arthur Jay, M.D., Columbus
 Timothy Brown, M.D., Crawfordsville
 Thomas Brubaker, M.D., Munster
 Everett Bickers, M.D., Floyds Knobs □

ISMA Fifty Year Club



Last year, 102 physician members were honored by the Indiana State Medical Association in recognition of their 50 years of service as loyal and devoted practitioners of medicine. These new members of the Fifty Year Club will join the roster of other distinguished Hoosier physicians inducted into the Fifty Year Club since its inception in 1948.

The Indiana State Medical Association wishes to formally acknowledge the following physicians for their unselfish service to their patients and profession:

Michael L. Allegretti, M.D., Lake County
 Uldarico A. Angeles, M.D., Lake County
 James W. Asher, M.D., Marion County
 Arnold J. Bachmann, M.D., Marion County
 W. Philip Ball, M.D., Delaware-Blackford County
 Helen B. Barnes, M.D., Johnson County
 Robert F. Barton, M.D., Steuben County
 Wallace E. Bash, M.D., Fort Wayne-Allen County
 Evart M. Beck, M.D., Marion County
 Robert O. Bill, M.D., Marion County
 William H. Bond, M.D., Marion County
 Charles T. Botkin, M.D., Delaware-Blackford County
 Otis R. Bowen, M.D., Marshall County
 Welbon D. Britton, M.D., Vigo-Parke-Vermillion County
 Edward L. Broomes, M.D., Lake County
 Thomas M. Brown, M.D., Delaware-Blackford County
 Franklin A. Bryan, M.D., Fort Wayne-Allen County
 Richard E. Buckingham, M.D., Owen-Monroe County
 Harold F. Burdette, M.D., Marion County
 William A. Clunie, M.D., Huntington County
 George L. Compton, M.D., Tipton County
 Vactor O. Connell, M.D., Marshall County
 Herbert L. Cormican, M.D., Elkhart County
 Alexander F. Craig, M.D., Marion County
 Robert A. Craig, M.D., Elkhart County
 James H. Crawford, M.D., Vanderburgh County
 John A. Crawford, M.D., Marion County
 Charles H. Crudden, M.D., Vanderburgh County
 Edward H. Daley, M.D., Marion County
 William D. Dannacher, M.D., Wabash County
 Joseph B. Davis, M.D., Grant County
 Thomas L. Dittmer, M.D., Porter County
 Joseph A. Dowd, M.D., Marion County
 Max M. Earl, M.D., Howard County
 Gail E. Eldridge, M.D., Marion County
 James C. Farr, M.D., Monroe County
 Robert J. Fenneman, M.D., Vanderburgh County
 Everett W. Gaunt, M.D., Madison County
 Charles E. Geckler, M.D., Delaware-Blackford County
 George N. George, M.D., Lake County
 William J. Gerding, M.D., Fort Wayne-Allen County
 George E. Godersky, M.D., St. Joseph County
 Benjamin F. Grant, M.D., Lake County
 Richard W. Halfast, M.D., Howard County
 Edgar A. Hawk, M.D., Marion County
 C. Jules Heritier, M.D., Whitley County
 Stephen Hermayer, M.D., Vanderburgh County
 Gilbert J. Himebaugh, M.D., Vanderburgh County
 J. Guy Hoover, M.D., Vanderburgh County
 William N. Horst, M.D., Lake County
 Joseph D. Howell, M.D., Marion County

Albin A. Jahns, M.D., Porter County
 Thomas James, M.D., Huntington County
 Joe H. Jewett, M.D., Marion County
 Nicholas C. Johns, M.D., St. Joseph County
 Walter E. Judson, M.D., Marion County
 Alexander J. Kahn, M.D., Marion County
 James C. Katterjohn, M.D., Marion County
 Jerome M. Korn, M.D., Lake County
 Frederick L. Kuhn, M.D., St. Joseph County
 Forrest R. LaFollette, M.D., Lake County
 Robert Y. Lee, M.D., Porter County
 Henry Leibundguth, M.D., Vanderburgh County
 James Z. Logan, M.D., Wayne-Union County
 John H. Mader, M.D., Wayne-Union County
 Salvo P. Marks, M.D., Lake County
 Griffith Marr, M.D., Bartholomew-Brown County
 Robert M. Maurer, M.D., Clay County
 James A. McClintock, M.D., Delaware-Blackford County
 Frank C. McDonald, M.D., Henry County
 Fletcher W. McDowell, M.D., Delaware-Blackford County
 Robert A. Mino, M.D., Vanderburgh County
 Isaac E. Michael, M.D., Marion County
 Edwin G. Moore, M.D., Lake County
 John H. Nill, M.D., Fort Wayne-Allen County
 Horace Norton, M.D., Daviess-Martin County
 William K. Patterson, M.D., Madison County
 Robert C. Peacock, M.D., Delaware-Blackford County
 Warren C. Polhemus, M.D., Madison County
 Wendell A. Prough, M.D., Wells County
 Richard C. Pryor, M.D., Marion County
 Harold E. Rendel, M.D., Miami County
 Alton H. Ridgway, M.D., Madison County
 Albert S. Ritz, M.D., Vanderburgh County
 Henry J. Rosevear, M.D., Lake County
 Robert L. Rouen, M.D., Elkhart County
 Keith R. Ruddell, M.D., Marion County
 Atee S. Salvo, M.D., Fountain-Warren County
 Cleon M. Schauwecker, M.D., Putnam County
 Theodore F. Schlaegel, M.D., Marion County
 Perry F. Seal, M.D., Fayette-Franklin County
 William M. Sholtz, M.D., Tippecanoe County
 John R. Showalter, M.D., Vigo-Parke-Vermillion County
 Fae H. Spurlock, M.D., Tippecanoe County
 Jean T. Stoops, M.D., Wabash County
 David L. Tennant, M.D., Fort Wayne-Allen County
 Robert W. Vermilya, M.D., Tippecanoe County
 Lawrence J. Vogel, M.D., Marion County
 Victor J. Vollrath, M.D., Marion County
 Roger L. Wilkinson, M.D., Madison County
 Julius B. Wohlfeld, M.D., Lawrence County
 J. William Wright Jr., M.D., Marion County □

■ auxiliary report



Kay Enderle, ISMA-A president, introduces, (from left) Jonathon Stafford, M.D., Bloomington; John Pulcini, M.D., Evansville; David Price, M.D., Indianapolis; and Susan Rogers, M.D., Marion, who spoke at the ISMA-A Breast Health Seminar Nov. 9 during the ISMA convention.



From left, Marilyn Krueger, ISMA-A health chairman; Linda Smart, guest speaker from the National Cancer Institute; and Kay Enderle, ISMA-A president, review the statistics of breast cancer after the ISMA-A Breast Health Seminar Nov. 9.



From left, Sue Ellen Greenlee, ISMA-A state membership chairman of Kendallville; Julie Alexander, guest speaker from Garland, Texas; and Kay Enderle, ISMA-A president of Terre Haute, wait for the start of the Round 'Em Up membership seminar, held Sept. 26 at the Embassy Suites North in Indianapolis.



Pictured at the ISMA-A Fund Raising Seminar held Oct. 17 at the Holiday Inn Airport in Indianapolis are, from left, Donna Dersch, state ISMA-A AMA ERF chairman; Sandy McCook, national AMA ERF chairman; James Carter, M.D., I.U. Medical Center; Martha Gerteisen, medical student; and Kay Enderle, ISMA-A president.

■ the wounded healer

ISMA Physician Assistance Program

D. Kete Cockrell, M.D.
Plainfield

As the new year begins, we would like to introduce the ISMA Physician Assistance Program and explain how it works.

Commission on Physician Assistance

The Commission on Physician Assistance (COPA) is one of five standing commissions of the ISMA. COPA is composed of 18 physician members appointed for three-year terms. A physician is chosen as a district representative from each of the 13 ISMA geographical districts. Additionally, four at-large physician members are selected. A medical resident, two medical students and two auxiliaries complete the membership. Current ISMA officers serve as ex-officio members. Candace Backer, a clinical social worker, serves as the ISMA Physician Assistance Program coordinator. D. Kete Cockrell, M.D., is the ISMA Physician Assistance Program medical consultant. Ms. Backer and Dr. Cockrell provide staff support and attend all commission/executive committee meetings as non-voting members.

The commission is dedicated to maintaining the quality of medical practice in Indiana by identifying physicians impaired by chemical dependency, psychiatric illness, physical illness and organic brain syndrome. Every effort is made to accomplish this goal through personal, confidential and anonymous service to the impaired physician, his family and colleagues. However, when such efforts fail, reports are made to the appropriate authorities (i.e., the Indiana Medical Licensing Board) to comply with state stat-

utes and maintain program integrity.

All policies and procedures related to program operation are discussed and approved by the full commission. These policies and procedures are then forwarded to the ISMA Board of Trustees for final approval. Included in these approved policies and procedures are:

1. proposals for program funding;
2. services to be rendered by the commission/program including:
 - educational forums
 - assessment of reports concerning physicians received by the ISMA
 - pre-assessment of physicians exhibiting signs and symptoms of impairment
 - planning/orchestrating/conducting interventions
 - assisting in the establishment of Hospital Staff/County Medical Society Physician Assistance Committees
 - developing cooperative working agreements with existing Hospital Staff/County Medical Society/Regional Physician Assistance Committees
 - direct assistance on a case-by-case basis to members of Hospital Staff/County Medical Society/Regional Physician Assistance Committees;
3. commission approved treatment centers for assessment and treatment of individuals entering the program;
4. intervention, treatment and continuing care contracts
5. random urine drug screen-

ing, including where they are done, 24-hour-per-day 7-day-a-week availability by program participant, observed, etc.; and

6. guidelines for actions to be taken when a physician fails to comply with recommendations for impairment evaluation or contractual conditions.

Notes

1. Commission members, Ms. Backer and Dr. Cockrell do not render treatment in any form to prospective program participants and/or program participants either as private therapists or representatives of the ISMA program.

2. No ISMA funds are used to pay for any form of treatment or urine drug screens, etc.

3. These guidelines provide for consultation between Ms. Backer, Dr. Cockrell and Executive Committee members of COPA before reporting non-compliance to anyone outside the program. Additionally, Ron Dyer, ISMA general counsel, is frequently consulted before any action is taken.

At its quarterly meetings, the commission: 1) reviews and approves the action of its Executive Committee; 2) is informed of actions taken by Ms. Backer and Dr. Cockrell since its last meeting and evaluates the actions for compliance with existing policies and procedures; 3) receives updates on cases being monitored and discusses recommendations, options and disposition of complicated cases; and 4) approves reports and recommendations to be forwarded to the Executive Committee of the ISMA Board of Trustees.

COPA Executive Committee

The COPA Executive Committee is composed of the chairman of the ISMA COPA and four mem-

■ the wounded healer

bers of the commission. The program coordinator and medical consultant serve as ex-officio members.

The Executive Committee is consulted through a conference call before any significant action is taken concerning a program participant (i.e., reporting to someone outside the program, such as the Indiana Medical Licensing Board).

Additionally, the committee meets monthly to:

1. review the actions taken by Ms. Backer and Dr. Cockrell assuring that these actions comply with approved policies and procedures;
2. discuss difficult cases and decide their disposition; and
3. review matters to be presented to the entire commission at its next meeting.

Minutes of the Executive Committee meeting are mailed to all members of the commission monthly.

Program accomplishments

In the last four years, ISMA's Physician Assistance Program has:

1. assisted in approximately 120 cases of physician impairment;
2. developed a mutually respectful and beneficial relationship with the Indiana Medical Licensing Board and Drug Enforcement Agency;
3. become recognized internationally as a "model" state program and presented as such at the International Impaired Physician Conference co-sponsored by the AMA and the Canadian Medical Association in Toronto in June 1991; and
4. achieved participation in the National Federation of State Physician Health Programs through Dr. Cockrell's election as first vice-president and member of its board of directors.

In summary, ISMA's Physician Assistance Program is de-

signed, governed and administered through the ISMA COPA and the ISMA Board of Trustees. Suggestions for program modifications (updating) frequently result from ISMA program staff networking at national meetings with staff members of state programs throughout the United States. Consequently, all current program policies and procedures are in compliance with program standards suggested by the National Federation of State Physician Health Programs. Consequently, our services to physicians and their families are based on the most current and effective prevailing accepted medical practices.

If we can help you, your family or associate, please call Candace Backer, 1-800-257-ISMA or (317) 261-1060. Your confidentiality and anonymity are vigorously protected. □

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

Rural Health★ **CARING** for the country

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

National Rural Health Association
15th Annual Conference on Rural Health
May 6-9, 1992
Hyatt Regency Crystal City
Washington, DC



SPECIALIZE IN AIR FORCE MEDICINE.

Become the dedicated physician you want to be while serving your country in today's Air Force. Discover the tremendous benefits of Air Force medicine. Talk to an Air Force medical program manager about the quality lifestyle, quality benefits and 30 days of vacation with pay per year that are part of a medical career with the Air Force. Find out how to qualify. Call

**USAF HEALTH PROFESSIONS
COLLECT
(317) 848-5830**



CARDIOLOGY – DIAGNOSTIC & INTERVENTIONAL



NASSER, SMITH AND PINKERTON CARDIOLOGY, INC.

William K. Nasser, M.D.
Michael L. Smith, M.D.
Cass A. Pinkerton, M.D.
James W. VanTassel, M.D.
Dennis K. Dickos, M.D.
John D. Slack, M.D.
Charles M. Orr, M.D.
Jane Howard, M.D.
James H. Adlam, M.D.
V. Michael Bournique, M.D.
Frank J. Green, M.D.
Nancy A. Branyas, M.D.
Charles P. Taliercio, M.D.
Bruce F. Waller, M.D.
Thomas F. Peters, M.D.
Azim Saqib, M.D.
Lawrence E. Gering, M.D.

providing

Cardiology & Cardiac Catheterization
Transesophageal Echocardiography
Doppler & Echocardiography
Exercise Stress Testing
Coronary Angioplasty
Nuclear Cardiology
Pacemaker Surveillance
Holter Monitoring
Percutaneous Valvuloplasty
Electrophysiology Testing
Coronary Atherectomy
Myocardial Biopsy
Automatic Implantable
Cardioverter Defibrillator
Signal Averaged Electrocardiography

Office: 317-871-6666

1-800-732-1482 (Indiana)

1-800-CHD-PTCA (Indiana)

1-800-CAD-PTCA (National)

FAX: 317- 871-6019

Suite 400

St. Vincent Professional Building

8402 Harcourt Road

Indianapolis, Indiana 46260

Kokomo Office:

620 South Berkley

Kokomo, IN 46901

317-456-1605

FAX: 317-457/3929

THE HEART CENTER OF INDIANA

CARDIOLOGY

FORT WAYNE CARDIOLOGY

Basil C. Genetos, M.D.
Robert W. Godley, M.D.
Michael J. Mirro, M.D.
Kevin J. Kelly, M.D.
Fred Doloresco, M.D.
John F. Phillips, M.D.
Patrick J. Daley, M.D.
William W. Wilson, M.D.
James J. Heger, M.D.
Raymond E. Dusman, M.D.
Charles F. Presti, M.D.
Stephen E. Brown, M.D.
David D. Whang, M.D.

Practice Limited to Cardiology
(Physician's Referral Only)

Locations nearby:

1912 Carew Street
Fort Wayne, Indiana 46805
(219) 482-4865 (800) 637-6505 (IN)
(800) 334-4371 (MI & OH)

Lutheran Medical Park
7900 W. Jefferson Blvd.
Suite 202
Fort Wayne, Indiana 46804
(219) 432-5613

Caring for people is the first priority at Fort Wayne Cardiology. Since 1978, our team approach has served referring physicians and their patients with the latest in heart care treatment and technologies.

Fort Wayne Cardiology is a trusted and caring group of people, featuring 13 board certified/board eligible cardiologists, as well as a special staff of nurses, technologists and administrative assistants. Patients are able to receive comprehensive cardiac services which include: cardiac catheterization, coronary angioplasty and atherectomy, electrophysiology, valvuloplasty, nuclear cardiology, doppler and echo cardiography, exercise stress testing, holter monitoring, ECG event monitoring, permanent pacemaker implantation and surveillance, non-invasive peripheral vascular evaluation, peripheral angioplasty and atherectomy, myocardial biopsy, transesophageal echo, AICD insertion and surveillance, signal average EKG, tilt table and rehab therapy.

University trained, certified cardiologists; the best in diagnostic equipment; clinical research and specialization within the specialty, makes Fort Wayne Cardiology an excellent center for heart care.

Satellite Clinics:

Angola	Kendallville	Defiance, OH
Auburn	LaGrange	Hicksville, OH
Columbia City	Wabash	
Huntington	Warsaw	

CARDIOLOGY

A new era in heart care has begun...

Now open



Robert E. Swint, Sr., M.D.

Mark A. Jones, M.D.

David A. Kaminskas, M.D.

Gary A. Hambel, M.D.

Mary H. Heintz, M.D.

Ravi N. Bathina, M.D.

Gregory C. Tomlinson, M.D.

Brian T. Lew, M.D.

Peter C. Hanley, M.D.

Christopher Zee-Cheng, M.D.

Steven W. Orlow, M.D.

David A. Belvedere, M.D.

Mark S. Hazen, M.D.

7836 W. Jefferson Blvd.

Fort Wayne, IN 46804

(219) 432-2297

800 Broadway, Suite 204

Fort Wayne, IN 46802

(219) 422-2558

3217 Lake Ave.

Fort Wayne, IN 46805

(219) 422-2297

2510 Dupont Rd.

Fort Wayne, IN 46825

(219) 489-8280

1-800-777-2297

CARDIOLOGY

Indiana Heart Physicians, Inc.

a member of the
Indianapolis Regional Heart Center
at St. Francis

Indianapolis/Beech Grove Medical Center
112 North 17th Avenue, Suite 300

Office	317-783-8800
Appointment Scheduling	317-781-3615
Cardiac Testing Center	317-781-3636
Toll Free (Nationwide)	800-992-2081

Consulting Offices at:

Greenwood
Shelbyville
Martinsville

Indiana Heart Physicians at Columbus
3154 North National Road, Suite C

Office	812-379-2020
Toll Free (Indiana)	800-331-4765

Physicians

H. O. Hickman, Jr., M.D., FACC
Thomas M. Mueller, M.D., FACC
J. Douglas Graham III, M.D., FACC
Kathleen H. Flohr, M.D., Ph.D., FACC
Jeffrey L. Christie, M.D., FACC
Stephen H. Kliman, M.D., FACC
Thomas C. Passo, M.D., FACC
Emily A. Diltz, M.D., FACC
John E. Batchelder, M.D., FACC
Mark D. Cohen, M.D., FACC
William J. Berg, M.D.
Thomas D. Hughes, D.O.
George E. Revtyak, M.D., FACC

at Columbus

David J. Hamilton, M.D., FACC
Kevin C. Preuss, M.D., FACC

providing

Cardiology and Cardiac
Catheterization
Coronary Angioplasty
Coronary Atherectomy
Electrophysiology
Percutaneous Valvuloplasty
Nuclear Cardiology
Stress Echocardiography
Exercise Stress Testing
Holter Monitoring
ECG Event Monitoring
Permanent Pacemaker Implantation
Pacemaker Surveillance
Color Flow Doppler Echocardiography
Laser Angioplasty
Trans-Telephonic Pacemaker Analysis

Noninvasive Peripheral
Vascular Evaluation
Signal Average EKG
Myocardial Biopsy
Tilt Table Testing

PLASTIC, RECONSTRUCTIVE & HAND SURGERY

One Call, Day or Night!

Our group is always available, 365 days a year, day or night; to see your patients in Indianapolis because there are times when your patient shouldn't have to wait.

**ALSO SEEING PATIENTS
BY APPOINTMENT IN THESE
CENTRAL INDIANA CITIES:**

DOWNTOWN
GREENCASTLE
DANVILLE
CRAWFORDSVILLE
LEBANON
KOKOMO
BEECH GROVE
GREENWOOD
MOORESVILLE
SURGERY CENTER



**SERVING 15 CENTRAL
INDIANA HOSPITALS**

VISA, MASTERCARD ACCEPTED
FINANCING AVAILABLE

ZOLLMAN CENTER FOR PLASTIC & HAND SURGERY

1633 North Capitol Avenue, Indianapolis, IN 46202



Member, American Society
of Plastic and Reconstructive Surgeons

**317-924-4943
1-800-332-3943
FAX: 317-921-3109**

Wally Zollman M.D., F.A.C., Twatchai Yamcharern M.D., Richard S. Troiano M.D., Rank O. Dawson, Jr., M.D.

PLASTIC SURGERY



AMERICAN SOCIETY OF
PLASTIC & RECONSTRUCTIVE
SURGEONS, INC.

John G. Pantzer Jr., M.D., F.A.C.S.
Diplomate, American Board
of Plastic Surgery

1801 North Senate Blvd., Suite 735
Indianapolis, Indiana 46202
317-929-5500

PLASTIC SURGERY

MERIDIAN PLASTIC SURGERY CENTER

For information on services
317/575-0110
or **800/352-7849**
106th & Meridian Streets
Indianapolis



An Ambulatory Surgery Center
Exclusively for Cosmetic, Plastic
and Reconstructive Surgery

Board-Certified Physicians

- Facial Plastic Surgery
- Plastic Surgery
- Ophthalmic Plastic Surgery
- Anesthesiology

Providing The Finest Surgical
Care And Treatment In A
Home-like Setting

Licensed by the Indiana State
Board of Health • Medicare
Certified

RADIOLOGY

SUPERB QUALITY DIAGNOSTIC RADIOLOGY AND RADIATION ONCOLOGY SERVICES ARE ONLY A TELEPHONE CALL AWAY...

Our mission is to provide caring, high quality, state-of-the-art imaging, interventional, and radiation oncological services to our patients, referring clinicians, and institutions. Call us today to discuss your unique requirements or to refer your patients for prompt, courteous, cost effective, and professional service.

INDIANAPOLIS

Methodist Hospital
1701 N. Senate Avenue
Methodist Professional Center
1801 North Senate Avenue
(317) 929-3580

Methodist Hospital Breast Cancer
Screening Program
(317) 929-5000

Eagle Highlands Radiologic Services
6920 Parkdale Place
Suite 111
(317) 291-4411

Lakeview Radiologic Services
9002 North Meridian Street
Suite 110
(317) 844-6944

BROWNSBURG

Brownsburg Radiologic Services
1375 North Green Street
Suite 200
(317) 852-3222



COLUMBUS

(Radiation oncology only)
Bartholomew County Hospital
2400 East Seventeenth Street
(812) 376-5361

CRAWFORDSVILLE

Culver Union Hospital
1710 Lafayette Road
(317) 364-3146

GREENSBURG

Decatur County Memorial Hospital
720 North Lincoln Street
(812) 663-1156

KOKOMO

(Radiation oncology only)
Howard Community Hospital
3500 South Lafountain Street
(317) 453-8189

TERRE HAUTE

(Radiation oncology only)
Union Hospital
1606 North Seventh Street
(812) 238-7504



RADIOLOGIC SPECIALISTS OF INDIANA, INC.

All Physicians Board Certified.

CLINICAL & ANATOMIC PATHOLOGY

The Medical Laboratory

of Drs. Thornton-Haymond-Costin-Buehl-Bolinger-Warner-McGovern-McClure-Hooker-Winkler
5940 West Raymond Street • Indianapolis, Indiana 46241

CHEMISTRY

MICROBIOLOGY

HEMATOLOGY

TOXICOLOGY

CYTOLOGY

HISTOLOGY

CUSTOMER SERVICE



Courier Service

24 hr. Pathology
Consultation

Assignment Accepted:
Medicare/Medicaid

BC/BS VIP and PC/USA,
Preferred Care, Prucare

18 Convenient Branch
Locations

CENTRAL TESTING FACILITY: 5940 W. Raymond St., Indianapolis, IN 46241
Phone: 317/248-2448

"Here Today To Serve You Tomorrow."

DOCTORS

This space is available.

For rates, write or call

INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-969-7545.

PULMONARY DISEASE

RESPIRATORY CONSULTANTS OF INDIANA

DAVID B. COOK, M.D., FCCP
CHRIS C. NAUM, M.D.

MICHAEL R. NIEMEIER, M.D., FCCP
THOMAS Y. SULLIVAN, M.D.
JOHN A. WARDEN, M.D., FCCP

ROBERT W. WELLER, M.D., FCCP
PATRICK E. WRIGHT, M.D., FCCP

Pulmonary Disease

Lung and lung-heart transplantation
Laser Bronchoscopy
Intra-bronchial radiation therapy
Trans-tracheal oxygen therapy
Complete rest and exercise
physiologic testing

Critical Care

Physicians ABIM certified in
critical care 24 hours/day
State-of-the-art eighty bed
intensive care facility

Hyperbaric Medicine

Diagnostic assessment
of local oxygen delivery
Treatment of disorders of
regional O₂ delivery and
utilization

Sleep Disorders

Clinical polysomnographer
Full-service polysomnography
laboratory

1801 N. SENATE BLVD., SUITE 400, INDIANAPOLIS, IN 46202 • OFFICE (317) 929-5820 • FAX (317) 929-3916
6920 PARKDALE PLACE, SUITE 215 • INDIANAPOLIS, IN 46254 • OFFICE (317) 328-6635 • FAX (317) 328-6640
GREENSBURG (812) 653-5533 • LEBANON (317) 873-2103 • RUSHVILLE (317) 932-4111 • TERRE HAUTE (812) 232-0564
AFTER HOURS: ANSWERING SERVICE (317) 926-3466 OR 1-800-772-7788

1-800-321-LUNG • MONDAY - FRIDAY 8:30 A.M. - 4:30 P.M.

ALCOHOLISM TREATMENT

Eugene G. Roach, M.D.
Executive/Medical Director



Anderson Center
of Saint John's

1-800-435-9143 or (317) 646-8383

- Comprehensive Alcohol and Drug Treatment
- Separate Programs for Adolescents and Adults
- Free Assessment and Intervention

ABDOMINAL SURGERY

TED W. GRISELL, M.D.

*Providing consultative services
for physicians throughout Indiana
for patients with
complex management problems*

5317 East 16th Street
Indianapolis 46218

317-359-8261
Phone answered 24 hours

■physicians' directory

INTERNAL MEDICINE

NEPHROLOGY & INTERNAL MEDICINE, INC.

Thomas Wm. Alley M.D. FACP Theodore F. Hegeman M.D.
George W. Applegate M.D. Douglas F. Johnstone M.D.
Richard Bloch M.D. Wendy L. Kindig M.D.
Charles B. Carter M.D. LeRoy H. King Jr. M.D. FACP
William H. Dick M.D. FACP Mary A. Margolis M.D.
Tim E. Taber M.D.

**1801 N. Senate Blvd., Suite 355
Indianapolis 46202
Tel: 317-924-8425**

By Physician Referral

Clinical Nephrology, Hemodialysis, Peritoneal Dialysis, Renal Transplantation, Metabolic Kidney Stone Disease, Hypertension, Fluid and Electrolyte Imbalance, Critical Care

HEMODIALYSIS

CHRONIC MAINTENANCE OUTPATIENT HEMODIALYSIS

DIALYSIS INSTITUTE OF ANDERSON
2629 Nichol Avenue
Anderson, Indiana 46011
317-649-0772

DIALYSIS INSTITUTE OF BEECH GROVE
3834 South Emerson Avenue
Indianapolis, Indiana 46203
317-787-3171

For further information contact
NEPHROLOGY & INTERNAL MEDICINE, INC.
1801 N. Senate Blvd., Suite #355
Indianapolis, Indiana 46202
317-924-8425

Outpatient renal consultation may be scheduled at any location.

HAND SURGERY

JOHN C. KLEIN, M.D.

Specializing in the diagnosis and treatment of hand, wrist, and forearm disorders.

2727 N. Pennsylvania St. 317-925-1665
Indianapolis, IN 46205 Answered 24 hours

**Diplomate American Board of Orthopedic Surgery
with certificate of added qualifications in surgery of the hand.**

HEMATOLOGY - ONCOLOGY

JOHN A. CAVINS, M.D.

8220 NAAB ROAD, SUITE 100
INDIANAPOLIS, INDIANA 46261
TELEPHONE (317) 876 1036

SERVING
INDIANAPOLIS CARMEL NOBLESVILLE

DERMATOPATHOLOGY

DERMATOPATHOLOGY LABORATORY

Larry J. Buckel, M.D.
Robert M. Hurwitz, M.D.

Howard R. Gray, M.D.
William B. Moores, M.D.



Diplomates of the American Boards
of
Dermatology and Dermatopathology

Specializing in
Inflammatory Skin Diseases
and
Neoplasms of the Skin

9202 North Meridian Street
Suite 215

Approved for and Accept
Medicare and Medicaid
Assignment

Indianapolis, Ind. 46260
(317) 843-2204

UPS Mailers and Courier Service Available

PSYCHIATRY

Eugene G. Roach, M.D.
Executive/Medical Director



Anderson Center
of Saint John's

1-800-435-9143 or (317) 646-8114

- Comprehensive Psychiatric Treatment
- Separate Programs for Adolescents, Adults and Older Adults
- Program for Dual Diagnosis

NEUROLOGY

Shirley M. Mueller, M.D.
General Neurology

Practice Dedicated Toward Problems Associated With
Numbness-Weakness-Dizziness And Pain Including Headache

Testing Available

317-871-6000

Indianapolis

North: St. Vincent's Professional Bldg. #726

South: Community South Professional Bldg., Suite M

PERIPHERAL VASCULAR SURGERY



VASCULAR SURGERY, P.C.

Austin L. Gardner, M.D.
Malcolm B. Herring, M.D.
Daniel R. LeGrand, M.D.
David L. Madison, M.D.
Spencer F. Goodson, M.D.
Sajjad M. Hussain, M.D.

St. Vincent Professional Building
8402 Harcourt Road
Suite 613
Indianapolis, Indiana 46260
Telephone (317) 871-6400
TOLL FREE (800) 662-5367

Carmel Medical Center
13450 North Meridian Street
Suite 160
Carmel, Indiana 46032
Telephone (317) 573-7040
TOLL FREE (800) 446-0298

Vascular
Diagnostics
Mobile
Non-invasive
Testing™



The Vascular Lab

**NONINVASIVE
VASCULAR TESTING**

The vascular lab offers a full spectrum of diagnostic vascular testing services, including the new addition of color computed sonography, supported by the entire team of:

John F. Ansbro, M.D. • Alan T. Marty, M.D. • H. Dan Adams, M.D.
Richard A. Murrell, M.D. • Daniel B. Daniels, M.D. • Jay Tuna, M.D.

Cardiovascular Surgery Inc.

350 West Columbia
Suite 350
Evansville, Indiana 47710
812-423-2395

■ physicians' directory

ASTHMA & ALLERGY

FRANK WU, M.D.



DIPLOMATE,
AMERICAN BOARD
OF ALLERGY &
IMMUNOLOGY

St. Vincent Professional Building
8402 Harcourt Road, Suite 606
Indianapolis, Indiana 46260
(317) 872-4213

ASTHMA & ALLERGY

MARK HOLBREICH, M.D.

**PEDIATRIC AND ADULT
ASTHMA, ALLERGY AND IMMUNOLOGY**

8803 N. Meridian St.
Suite 365
Indianapolis, Indiana
(317) 574-0230

- Asthma
- Chronic Cough
- Rhinitis
- Adverse Food Reactions
- Drug Sensitivity
- Stinging Insect Allergy

COLON & RECTAL SURGERY

KCRA



Kendrick Colon
and Rectal Associates

William M. Kendrick, M.D.
George A. Donnally, M.D.
R. James Wilson, M.D.

William E. Kelley, M.D.
Richard L. Stout, M.D.
Paula A. Hall, M.D.

William M. Sobat, M.D.

*Specialists in the Diagnosis and Treatment of Colon and Rectal Disease
General Surgery Services Available*

For more information call: **Kendrick Colon & Rectal Associates,**
Tel: **317-831-9300 or 1-800-222-7994**

Kendrick Memorial Hospital, Mooresville, Indiana

(JCAHO Accredited)

Regional Offices: Muncie, Kokomo & Greensburg

ONCOLOGY — HEMATOLOGY

**INDIANA ONCOLOGY HEMATOLOGY
CONSULTANTS**



1-800-ONC-HEME
1-800-662-4363

Central: 317-927-5770
St. Francis: 317-783-8509

ADULT ONCOLOGY HEMATOLOGY — CENTRAL OFFICE

1828 N. Illinois Street Indianapolis, IN 46202 927-5770

Laurence H. Bates, M.D.
William M. Dugan, Jr., M.D.
Redmond P. Hogan, III, M.D.

Gregory W. Smith, M.D.
William H. Bond, M.D.

PEDIATRIC ONCOLOGY HEMATOLOGY — CENTRAL OFFICE

1828 N. Illinois Street Indianapolis, IN 46202 927-5770

Arthur J. Provisor, M.D.

Deborah S. Provisor, M.D.

ADULT ONCOLOGY HEMATOLOGY — ST. FRANCIS OFFICE

1600 Albany — Medical Clinic Bldg. Beech Grove, IN 46107 783-8509

Redmond P. Hogan, III, M.D.

Randall C. Trowbridge, M.D.
Gregory W. Smith, M.D.

*Central Office Located in the Byram Gates Middleton House
Listed on the National Register of Historic Places*

RADIATION ONCOLOGY



Physicians:
ROGER ROBISON
DAVID BELL
TAE CHUNG

Radiation Oncology Services for Southwest Indiana

TERRE HAUTE
Regional Hospital
(812) 234-7756

VINCENNES
Good Samaritan Hospital
(812) 885-3939

ROGER ROBISON, M.D., F.A.C.P.
M.D. Anderson, 1980
Certified: Radiation
Oncology
Medical Oncology

DAVID BELL, M.D., Ph.D.
M.D. Anderson, 1981
Certified: Radiation
Oncology

TAE CHUNG, M.D.
Chicago Hines, V.A., 1976
Certified: Radiation
Oncology

RADIATION ONCOLOGY

TRI-STATE RADIATION ONCOLOGY

Evansville Cancer Center
Evansville, Indiana
(812) 474-1110



Welborn Cancer Center
Evansville, Indiana
(812) 426-8373

AL KORBA, M.D.; ALY RAZEK, M.D.
THOMAS HAYES, M.D.; AMR AREF, M.D.; SHANNON LAMB, M.D.

★ ★ ★ ★ ★

Tri-County Cancer Care Center
Jasper, Indiana
(812) 482-2212

DEVIDAS SHETH, M.D.

Tri-County Cancer Care Center
Princeton, Indiana
(812) 386-6663

MOISES DOMINGO, M.D.

★ ★ ★ ★ ★

Olney Cancer Center
Olney, Illinois
(618) 392-3050

MOISES DOMINGO, M.D.

Harrisburg Oncology Associates
Harrisburg, Illinois
(618) 252-5126

MANJU GUPTA, M.D.

★ ★ ★ ★ ★

Radiation Oncology
Owensboro, Kentucky
(502) 926-7228

TRISTAN BRIONES, M.D.

Henderson Cancer Center
Henderson, Kentucky
(502) 827-0255

AMR AREF, M.D.

★ ★ ★ ★ ★

In Indiana 1-800-843-7117 • Out of Indiana 1-800-331-9294
24-hour answering service (812) 476-1367

■physicians' directory

ONCOLOGY



Oncology Associates

Michael A. Cross, M.D.
Board Certified, Radiology (Therapeutic)

John R. Pancoast, M.D.
Board Certified, Internal Medicine
and Medical Oncology/Hematology

John F. Sacco, M.D.
Board Certified, Internal Medicine
and Radiology (Therapeutic)

Offering comprehensive cancer care, including:

- Cancer Detection
- Chemotherapy
- Radiation Therapy (Linear Accelerator)
- Biologic Therapy
- Education and Support Services
- Hospital, Home and Hospice Care

Dearborn County Hospital Professional Building
606 Wilson Creek Road, Suite 130
Lawrenceburg, Indiana 47025
(812) 537-1911

Oncology Associates' 16 physician members have additional offices in Cincinnati, Montgomery and Middletown, Ohio; and Crestview Hills, Kentucky. The practice offers outpatient care and clinics in 11 hospitals throughout the Tri-State area.

ORTHOPAEDIC SURGERY

JAMES L. KAISER, M.D.



- ORTHOPAEDIC SURGERY
- FRACTURES
- BACK SURGERY
- FOOT SURGERY
- ARTHROSCOPIC SURGERY

Certified American Board
Of Orthopaedic Surgery

5626 East 16th Street
Indianapolis, IN 46218

(317) 352-0176
OFFICE ANSWERS DAY & NIGHT

5626 E 16
82nd & Shadeland
If No Answer Call

352-0176
352-0176
543-6089

DOCTORS

This space is available.

For rates, write or call
INDIANA MEDICINE, 322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

TRANSPLANTATION

METHODIST TRANSPLANT CENTER

P.O. Box 1367
1701 N. Senate Blvd.
Indianapolis, Indiana 46206



24 - HOUR REFERRAL
(800) 772-7788

HEART TRANSPLANTATION

Surgical Director
Harold Halbrook, M.D.
Program Cardiologist:
Douglas Pitts, M.D.

LUNG TRANSPLANTATION

Surgical Director
Harold Halbrook, M.D.
Program Pulmonologist:
Michael Niemeier, M.D.

KIDNEY TRANSPLANTATION PANCREAS TRANSPLANTATION

Surgical Director
Brian Haag, M.D.
Program Nephrologist:
Charles Carter, M.D.

LIVER TRANSPLANTATION

Surgical Director
Dale A. Rouch, M.D.
Program Gastroenterologists:
Peds - Susan Maisel, M.D.
Adult - Brian G. Sperl, M.D.

CORNEAL TRANSPLANTATION

Surgical Director
Stephen Johnson, M.D.

TISSUE/BONE BANK

Surgical Director
David A. Fisher, M.D.

BONE MARROW TRANSPLANTATION

Co-Director
Luke Akard, M.D.
Co-Director

ORTHOPAEDIC SURGERY

PERFORMANCE



IN A HIGH-PERFORMANCE SPORTS CAR, THE SPOKES ARE AN INTEGRAL PART OF THE ENGINEERING. EACH INDIVIDUAL SPOKE IS STRONG, YET IT'S THE WAY THEY'RE INTERWOVEN THAT GIVES EXCEPTIONAL STRENGTH AND BALANCE.

THAT'S THE WAY IT IS AT ORTHOPAEDICS INDIANAPOLIS. EACH OF OUR 19 PHYSICIANS HAS UNIQUE INDIVIDUAL STRENGTHS AND SKILLS. THE ABILITY TO DRAW ON EACH OTHER'S SPECIAL EXPERTISE STRENGTHENS OUR CAPABILITIES AND ENHANCES OUR PERFORMANCE.

AS THE EXCLUSIVE PROVIDER OF RAPID AND EXTENSIVE ORTHOPAEDIC RECONSTRUCTIVE SURGERY FOR METHODIST HOSPITAL'S EMERGENCY MEDICINE AND TRAUMA CENTER, WE TREAT OVER 1,000 TRAUMA CASES A YEAR PROVIDING US WITH EXPERIENCE IN EVERY FACET OF ORTHOPAEDIC CARE. THAT'S WHY DOCTORS FROM ALL 50 STATES AND 11 FOREIGN COUNTRIES HAVE SOUGHT OUR HELP TREATING THEIR MOST COMPLEX CASES.

DONALD S. BLACKWELL, M.D.
F.R. BRUECKMANN, M.D., F.A.C.S.
ANTHONY R. LASICH, M.D.
WILLIAM O. IRVINE, M.D.
JOSEPH C. RANDOLPH, M.D.
DONALD E. RUSSELL, M.D.
MARK R. STEVENS, M.D.
TERRY R. TRAMMELL, M.D.
ANDREW J. VICAR, M.D.
VINCENT L. FRAGOMENI, M.D.
JOHN K. SCHNEIDER, M.D.
JOSEPH R. BAELE, M.D.
SANFORD S. KUNKEL, M.D.
DAVID A. FISHER, M.D.
D. KEVIN SCHEID, M.D.
MICHAEL F. COSCIA, M.D.
HENRY G. STEIN, M.D., F.A.C.S.
ORTHOPAEDIC SURGEONS
ROBERT C. GREGORI, M.D.
PHYSICAL MEDICINE & REHABILITATION

JOINT RECONSTRUCTION
TRAUMA
FRACTURE CARE
SPORTS MEDICINE
SCOLIOSIS
SPINAL SURGERY
SHOULDER SURGERY
HAND SURGERY
FOOT SURGERY
ARTHROSCOPIC SURGERY
PEDIATRIC ORTHOPAEDICS
ADULT ORTHOPAEDICS
ILIZAROV LIMB LENGTHENING
& DEFORMITY CORRECTION



**ORTHOPAEDICS
INDIANAPOLIS**

INDIANAPOLIS • DANVILLE
GREENCASTLE • SPEEDWAY
ZIONSVILLE
317-923-5352
1-800-223-3381

ORTHOPAEDICS & SPORTS MEDICINE

Hoosier Orthopaedics & Sports Medicine, P.C.

The Foot Program staff medically manages
common foot problems such as:

Ingrown Toenails
Mortons Neuroma
Hammer Toes
Bunions
Bunionette
Foot Strain
Soft Corns
Corns
Calluses
Planter Warts

Special emphasis on diabetic and rheumatoid
arthritis foot problems. The services of a
Pedicurist are available by appointment.

Office Answers Day and Night

13450 North Meridian Street, Suite 355, Carmel, Indiana 46032
(317) 575-2705

8330 Naab Road, Suite 234, Indianapolis, Indiana 46260
(317) 870-7075



Robert M. Palmer, M.D.

Frank B. Throop, M.D.

Robert T. Clayton, M.D.

Robert E. Cravens, M.D.

John E. Garber, M.D.

Thomas F. Trainer, M.D.

COMPREHENSIVE REHABILITATION

We're Working to Make Life Better

At Kokomo Rehabilitation Hospital, we're committed to only one specialized field – rehabilitation medicine.

This central focus means your patients receive the therapy and care needed to restore their lives to the fullest extent possible.



**Kokomo
Rehabilitation
Hospital**

Our newly opened, 60-bed hospital features sophisticated high-tech equipment, a total barrier-free environment and highly trained therapists.

Give us a try. Your patients and you will be pleased with the results.

– William J. Lester, MD,
Medical Director

Bringing the Quality Back to Life for Patients Affected by:

Stroke • Traumatic Brain Injury • Spinal Cord Injury • Amputation • Orthopedic Disorders • Neurological Disorders • Arthritis • Back and Neck Injuries • Chronic Pain • Multiple Trauma • Return to Work
• Carpal Tunnel Syndrome and other Cumulative Trauma Disorders

829 Dixon Road • Kokomo, Indiana 46901

General Hospital Information
(317) 452-6700

For Referral or Admission Information
1-800-886-LIFE

A Continental Medical Systems Facility

DOCTORS

This space is available.

For rates, write or call
INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

MULTI-SPECIALTY GROUP PRACTICE

Addictionology
Allergy
Cardiovascular Diseases
Dermatology
Endocrinology
Family Practice
Gastroenterology
Gynecology
Hematology-Oncology
Internal Medicine
Neurology
Nephrology
Nuclear Medicine
Obstetrics
Ophthalmology
Orthopedics
Otolaryngology
Pediatrics
Psychiatry
Pulmonary Medicine
Rheumatology
Surgery
Urology



**Welborn
Clinic**

421 Chestnut Street
Evansville, Indiana 47713
(812)426-9440

Toll-free in Indiana:
1-800-521-0269

Westside Family Practice Ctr.
(812)429-1818

Welborn Clinic East
(812)474-7123

Welborn Clinic Highland
(812)426-9565

In Newburgh:
Welborn Clinic Newburgh
(812)853-7391

In Reo:
Reo Family Practice Center
(812)649-5061

isma leadership

OFFICERS

President — C. Dyke Egnatz, Schererville
 Pres.-elect — William H. Beeson, Indianapolis
 Immediate Past Pres — Michael O. Mellinger, LaGrange
 Executive Director — Richard R. King, Indianapolis
 Treasurer — John A. Bizal, Evansville
 Asst. Treasurer — Timothy Brown, Crawfordsville
 Speaker — William C. Van Ness II, Summitville
 Vice Speaker — William E. Cooper, Columbus

EXECUTIVE COMMITTEE

*C. Dyke Egnatz, Schererville
 William H. Beeson, Indianapolis
 Michael O. Mellinger, LaGrange
 Peter Winters, Indianapolis
 John A. Bizal, Evansville
 Timothy Brown, Crawfordsville
 Alfred Cox, South Bend
 Jerome Melchior, Vincennes
 William C. Van Ness II, Summitville
 William E. Cooper, Columbus

TRUSTEES (Terms end in October)

District

- 1 — Bruce Romick, Evansville (1992)
- 2 — Jerome E. Melchior, Vincennes (1993)
- 3 — Gordon L. Gutmann, Jeffersonville (1994)
- 4 — Arthur C. Jay, Lawrenceburg (1992)
- 5 — Fred E. Haggerty, Greencastle (1993)
- 6 — Ray Haas, Greenfield (1994)
- 7 — Donna J. Meade, Indianapolis (1992)
- 7 — John M. Records, Franklin (1993)
- *7 — Peter I. Winters, Indianapolis (1994)
- 8 — John V. Osborne, Muncie (1993)
- 9 — Stephen Tharp, Frankfort (1994)
- 10 — Nicholas L. Polite, Hammond (1992)
- 11 — Jack W. Higgins, Kokomo (1993)
- 12 — John R. Thomas, Fort Wayne (1994)
- 13 — Alfred C. Cox, South Bend (1992)
- RMS — Rick Robertson, Indianapolis (1992)
- MSS — Andre Stovall, Indianapolis (1992)

*Chairman

ALTERNATE TRUSTEES (Terms end in October)

District

- 1 — Barney R. Maynard, Evansville (1994)
- 2 — James P. Beck, Washington (1992)
- 3 — John H. Seward, Bedford (1992)
- 4 — Robert L. Forste, Columbus (1994)

- 5 — Roland M. Kohr, Terre Haute (1994)
- 6 — Howard C. Deitsch, Richmond (1992)
- 7 — Ronald G. Blankenbaker, Indianapolis (1994)
- 7 — Bernard J. Emkes, Indianapolis (1992)
- 7 — Charles O. McCormick III, Greenwood (1993)
- 8 — Susan K. Pyle, Union City (1994)
- 9 — Robert E. Darnaby, Rensselaer (1992)
- 10 — Frank M. Sturdevant, Valparaiso (1994)
- 11 — Laurence K. Musselman, Marion (1992)
- 12 — Charles M. Frankhouser, Fort Wayne (1992)
- 13 — Richard J. Houck, Michigan City (1994)
- RMS — Carla Brumbaugh, Indianapolis (1992)
- MSS — Ruchir Sehra, Indianapolis (1992)

AMA DELEGATES (Terms end Dec. 31)

Marvin E. Priddy, Fort Wayne (1993)
 John D. MacDougall, Beech Grove (1993)
 Herbert Khalouf, Marion (1993)
 John A. Knot, Lafayette (1992)
 Alvin J. Haley, Carmel (1992)
 George T. Lukemeyer, Indianapolis (1992)

AMA ALTERNATE DELEGATES (Terms end Dec. 31)

Michael O. Mellinger, LaGrange (1993)
 George Rawls, Indianapolis (1993)
 Richard L. Reedy, Yorktown (1993)
 Shirley Thompson Khalouf, Marion (1992)
 Max N. Hoffman, Covington (1992)
 Edward L. Langston, Indianapolis (1992)

DISTRICT OFFICERS AND MEETINGS

- 1 — Pres. Richard A. Tibbals, Evansville
 Secy: Rex H. Ragsdale, Evansville
 Annual Meeting: May 21, 1992
- 2 — Pres: Paul Daluga, Linton
 Secy: Frederick R. Ridge, Jr., Linton
 Annual Meeting: May 14, 1992
- 3 — Pres: Stephen R. Havens, Jeffersonville
 Secy: Olegario J. Ignacio, Jeffersonville
 Annual Meeting: May 20, 1992
- 4 — Pres: Robert L. Forste, Jr., Columbus
 Secy: Jeffery C. Hagedorn, Columbus
 Annual Meeting: May 6, 1992
- 5 — Pres: James R. Rudolph, Greencastle
 Secy: Peggy Sankey-Swaim, Rockville
 Annual Meeting: May 28, 1992
- 6 — Pres: Dennis L. Roberts, Shelbyville
 Secy: William H. Toedebusch, Richmond
 Annual Meeting: May 13, 1992

- 7 — Pres: Bernard J. Emkes, Indianapolis
 Secy: H. Marshall Trusler, Greenfield
 Annual Meeting: To be announced
- 8 — Pres:
 Secy:
 Annual Meeting: June 3, 1992
- 9 — Pres: Robert E. Darnaby, Rensselaer
 Secy: Stephen D. Tharp, Frankfort
 Annual Meeting: June 10, 1992
- 10 — Pres: Filemon P. Lopez, Dyer
 Secy: Barron M. Palmer, Hammond
 Annual Meeting: June 17, 1992
- 11 — Pres: Regino Urgena, Marion
 Secy: Frederick C. Poehler, La Fontaine
 Annual Meeting: Sept. 16, 1992
- 12 — Pres: William Aeschliman, Fort Wayne
 Secy: Joseph Manthey, Bluffton
 Annual Meeting: Sept. 17, 1992
- 13 — Pres: David Haines, Warsaw
 Secy: John W. Schurz, South Bend
 Annual Meeting: Sept. 9, 1992

COMMISSION CHAIRMEN

Constitution and Bylaws

Helen E. Czenkusch, Indianapolis

Legislation

Eugene G. Roach, Anderson

Physician Assistance

Robert Nelson, South Bend

Medical Services

Dallas E. Coate, Lebanon

Medical Education

James E. Carter, Indianapolis

Sports Medicine

Ronald G. Blankenbaker, Indianapolis

COMMITTEE CHAIRMEN

Medical Malpractice (Ad Hoc)

George T. Lukemeyer, Indianapolis

Grievance

Richard B. Schnute, Indianapolis

Indiana Medical Foundation

Frank B. Ramsey, Indianapolis

CHAIRMEN OF ISMA SPECIALTY SECTIONS

ALLERGY

Paul D. Isenberg, Indianapolis

ANESTHESIOLOGY

Stephen F. Dierdorf, Indianapolis

CUTANEOUS MEDICINE

Peter I. Winters, Indianapolis

DIRECTORS MEDICAL EDUCATION

Glenn Bingle, Indianapolis

EMERGENCY MEDICINE

Thomas C. Madden, Greenwood

FAMILY PRACTICE

Dallas F. Coate, Lebanon

INTERNAL MEDICINE

Neil Erick, Indianapolis

MEDICAL DIRECTORS AND STAFF PHYSICIANS OF NURSING FACILITIES

Larry G. Cole, Yorktown

NEUROLOGICAL SURGERY

Marvin R. Bernard, Merrillville

NEUROLOGY

Charles A. Bonsett, Indianapolis

NUCLEAR MEDICINE

Mike Mullinix, Indianapolis

OBSTETRICS & GYNECOLOGY

Philip N. Eskew Jr., Carmel

OPHTHALMOLOGY

D. Dean Cofield, Bloomington

ORTHOPAEDIC SURGERY

James G. Buchholz, Fort Wayne

OTOLARYNGOLOGY, HEAD & NECK SURGERY

William F. Cooper, Columbus

PATHOLOGY & FORENSIC MEDICINE

Joyce Byllesby, Washington

PEDIATRICS

Charlene Graves, Indianapolis

PHYSICAL MEDICINE AND REHABILITATION

Robert Gregori, Indianapolis

PREVENTIVE MEDICINE AND PUBLIC HEALTH

Gary A. Babcoke, Chesterton

PSYCHIATRY

Patricia Sharpley, Indianapolis

RADIOLOGY

Gonzalo T. Chua, Indianapolis

SURGERY

Robert Lempke, Indianapolis

UROLOGY

Rodney A. Mannion, LaPorte

ISMA KEY STAFF

Richard R. King, Executive Director

Adele Lash, Director of Operations/Communications

Mike Abrams, Director of Marketing/Legislation

John Wilson, Director of Administration

Ronald Dyer, General Counsel

Susan Grant, Executive Assistant

Richard Ryan, Field Services (Northern)

Bob Sullivan, Field Services (Central)

Janna Kosinski, Field Services (Southern)

Barbara Walker, Reimbursement Coordinator

Tom Martens, Members Health Insurance

Tina Sims, INDIANA MEDICINE

■ from the museum

Physicians and surgeons in the mid 19th century not only experienced difficulty operating sphygmographs and sphygmomanometers but also discovered that these devices, when working properly, often provided inconsistent results.

Seeking new instruments to assist with clinical diagnosis, medical practitioners readily turned to the sphygmograph, which records the arterial pulse, and the sphygmomanometer, which measures blood pressure, when these devices were introduced. Physicians and surgeons soon realized, however, that the early versions of these instruments provided little information to help identify specific disorders.

French physiologist Etienne Jules Marey introduced the sphygmograph in 1860. Designed to measure the pulse at the radial artery near the thumb's base, the sphygmograph was strapped to the patient's wrist and was situated to ensure that the device's ivory button occurred directly over the patient's artery.

With the use of a sensitive spring, the sphygmograph transmitted the pulse wave from the button to a stylus that subsequently rose and fell to record the pulse's frequency and degree of regularity. The stylus marked the resulting data on a strip of smoked paper that was moved forward about four inches every 10 seconds by a clockwork mechanism.

Besides the difficulty in interpreting the importance of these measurements, physicians also encountered problems with the

variances that occurred in the readings from instrument to instrument. Since no method existed to calibrate the sphygmograph, identical instruments could exert different pressures on the radial artery and, therefore, even produce two different readings for the same individual's pulse.

Unlike the sphygmograph, the sphygmomanometer recorded the actual arterial blood pressure of the patient. Early 19th century versions required the physician to insert a cannula into the artery, thereby allowing the blood to exert pressure directly upon a column of mercury, the tube of which registered the arterial pressure in millimeters.

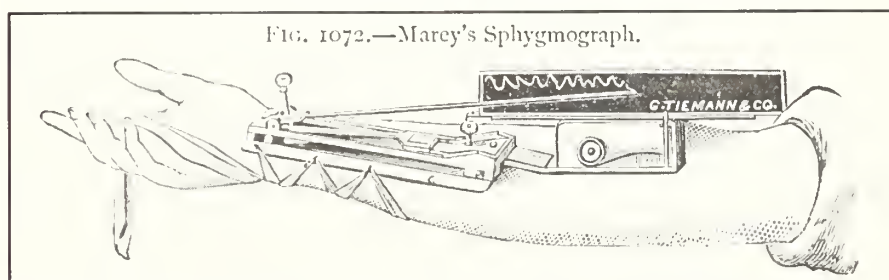
Consequently, this direct method of measuring arterial pressure relegated the use of the instrument to a laboratory procedure. However, in 1889, Samuel Siegfried Ritter von Basch, a Czech physician teaching physiology in Vienna, introduced a sphygmomanometer that enabled a physician to indirectly measure the arterial blood pressure of the patient.

The instrument created by von Basch contained an aneroid manometer instead of the mercury

column and, more importantly, used a water-filled bulb of pelotte instead of a cannula to measure the arterial pressure. To operate the device, the physician placed the pelotte over the radial artery and increased the water pressure upon the pelotte until the pulse sound, monitored by a stethoscope, disappeared. The reading that resulted at this point indicated the systolic pressure.

Although this instrument possessed greater clinical applications, specialists rather than general practitioners primarily used the sphygmomanometer. However, the device achieved widespread popularity when Oscar H. Rogers, M.D., chief medical director of the New York Life Insurance Company, introduced an aneroid manometer that used air instead of water to compress the artery.

The Indiana Medical History Museum in Indianapolis currently displays several sphygmomanometers from its collection. The museum is located on the grounds of Central State Hospital. Visitors may enter the museum at 3045 W. Vermont St. or the hospital's entrance on Warman Street. □



This 1889 catalog produced by George Tiemann & Co. depicts the proper method to use the sphygmograph invented by Etienne Jules Marey.

■ cme calendar

Indianapolis Heart Center

The Indianapolis Regional Heart Center at St. Francis Hospital will sponsor these CME courses:

- Jan. 22-23 - Cardiac Nursing Refresher Course: Overview of Cardiology.
- Feb. 6-7 - Cardiac Pharmacology Refresher Course: Overview of Cardiology.
- Feb. 11-12 - Cardiac Nurses Refresher Course: Overview of Cardiology.
- Feb. 19-20 - Cardiac Nurses Refresher Course: Overview of Cardiology.
- Feb. 22 - Critical Care Nurses Conference, Hyatt Regency, Indianapolis.
- Feb. 22-23 - Cardiology Update '92, Hyatt Regency, Indianapolis.
- Mar. 2-3 - Cardiac Pharmacology Refresher Course: Overview of Cardiology.
- Mar. 16-17 - Cardiac Nurses Refresher Course: Overview of Cardiology.
- Mar. 18 - A Woman's Heart, Holiday Inn Union Station, Indianapolis.
- Mar. 24-25 - Cardiac Nurses Refresher Course: Overview of Cardiology.

Unless listed otherwise, all

courses will be held at the Indianapolis Regional Heart Center at St. Francis Hospital. For more information on these courses, call Marsha Breen at (317) 783-2776.

St. Mary's Medical Center

St. Mary's Medical Center in Evansville will sponsor these courses:

- Feb. 6 - The Heart Seminar: Rates and Rhythms.
- Feb. 20 - The MacKenzie Lecture: Stress Incontinence.
- Mar. 5 - The G.I. Seminar: Lengthy Abberations.

These courses will be held at St. Mary's Medical Center, 3700 Washington Ave., in Evansville. For more information, call (812) 479-4468.

University of Michigan

The University of Michigan Medical School will sponsor these courses:

- Jan. 27-29 - Fiberoptics Workshops for the Difficult Airway, Disney's Yacht and Beach Club Resorts, Lake Buena Vista, Fla.
- Feb. 2-7 - Midwinter Family Practice Update, Boyne Highlands Inn, Harbor Springs, Mich.
- Feb. 28-Mar. 1 - Advances in the Management of Infectious Diseases:

Update 1992, South Seas Plantation, Captiva Island, Fla.

- Mar. 8-11 - Fiberoptics Workshops for the Difficult Airway, Red Lion's La Posada Resort, Scottsdale, Ariz.
- Mar. 17-21 - Family Practice, 15th Annual Spring Review Course, The Towsley Center, Ann Arbor, Mich.

For more information on these courses, call Angela Voeller at (313) 763-1400.

University of Wisconsin

The University of Wisconsin School of Medicine will sponsor these courses:

- Feb. 28-29 - Orthopaedics in Primary Care, Edgewater Hotel, Madison, Wis.
- Apr. 1-3 - Electrophysiologic Basis for the Diagnosis and Management of Cardiac Arrhythmias, Hyatt Regency Hotel, Milwaukee, Wis.
- Apr. 23-24 - The Heart of Cardiology is (Still) Echocardiology, Marc Plaza Hotel, Milwaukee, Wis.

For more information, call Sarah Aslakson at (608) 263-2856. □

■ obituaries

William M. Anshutz, M.D.

Dr. Anshutz, 74, a retired Indianapolis radiologist, died Nov. 15 at his home.

He was a 1948 graduate of the Ohio State University College of Medicine. He was an Army veteran of World War II, an Air Force veteran of the Korean War and a recipient of the Bronze Star.

Dr. Anshutz had been affiliated with Methodist Hospital in Indianapolis and Witham Hospital in Lebanon before retiring in 1983. He also was a physician for the Indianapolis 500-Mile Race for many years.

William F. Kerrigan, M.D.

Dr. Kerrigan, 71, a retired Connersville general practitioner, died Nov. 6 at his home.

He was a 1945 graduate of the Indiana University School of Medicine and an Army Air Force Medical Corps veteran of World

War II.

Dr. Kerrigan practiced medicine 38 years in Connersville before retiring in 1990. He was a staff member of Fayette Memorial Hospital in Connersville and Rush Memorial Hospital in Rushville. He had served on the Fayette County Health Board.

Samuel A. Motanya, M.D.

Dr. Motanya, 42, a Fort Wayne obstetrician/gynecologist, died Oct. 30.

He was a 1984 graduate of the Howard University College of Medicine. A native of Nigeria, he came to the United States 20 years ago.

Dr. Motanya began practicing medicine in Fort Wayne seven years ago. He was chairman of the obstetrics and gynecology department at St. Joseph Medical Center and also had worked at the Three Rivers Health Services.

Ladislav D. Wojcik, M.D.

Dr. Wojcik, 72, a Marion pediatrician, died Nov. 5 at Marion General Hospital.

She was a 1949 graduate of Harvard University Medical School.

Dr. Wojcik had practiced in Marion since 1954. She was chief of the pediatric staff at Marion General Hospital, director of the Salk Polio Vaccine program and a board member of the Grant-Blackford Development Center. She was former president of the March of Dimes Foundation, Opportunity Industries and the Grant County Retarded Children's Association. Before coming to Marion, she did research at the Blood Fractionation Laboratory at Harvard and worked at Children's Medical Center in Boston. □

Look-alike and sound-alike drug names

Category:	DUPHALAC Laxative	DICLOFENAC Nonsteroidal anti-inflammatory agent
Brand name:	Duphalac, Reid-Rowell	Voltaren, Geigy
Generic name:	Lactulose	Diclofenac sodium
Dosage forms:	Syrup	Tablets
Category:	TRENTAL Hemorheologic	TORADOL Non-narcotic analgesic
Brand name:	Trental, Hoechst-Roussel	Toradol, Syntex
Generic name:	Pentoxifylline	Ketorolac
Dosage forms:	Tablets	Injection

■ drug names

Benjamin Teplitzky, R. Ph.
Brooklyn, N.Y.

Look-alike and sound-alike drug names can be misinterpreted by a nurse reading doctors' orders or by a pharmacist compounding physicians' prescriptions.

Such misunderstandings can result in the administration of a drug not intended by the prescriber. Awareness of such look-alike and sound-alike drug names can reduce potential errors. □

■ people

Dr. Jim Calli of Bloomington was selected to coordinate Bloomington Hospital's participation in the largest U.S.-based cardiovascular medicine study. Cleveland Clinic Foundation and Duke University Medical Centers are conducting the study, Global Utilization of Streptokinase and TPA for Occluded Coronary Arteries.

Dr. Clarence G. Clarkson, a Richmond family practitioner, received the Paul S. Rhoads Humanity in Medicine Award at Reid Memorial Hospital. The award recognizes a physician whose "contributions to health care delivery have exceeded usual expectations ... and highlights those acts of giving which have had an effect on personal lives or institutions."

Dr. Jeffrey C. Darnell and **Dr. Patricia A. Keener**, both of Indianapolis, received the Tony and Mary Hulman Health Achievement Awards from the Indiana Public Health Foundation for their contributions to the aged population and preventive medicine. Dr. Darnell specializes in geriatric medicine at the Indiana University Medical Center, and Dr. Keener is chief of pediatrics at Wishard Hospital.

Dr. Thomas M. Kolakovich has been named the medical director of Chelsea Manor in Elkhart.

Dr. Kenneth E. Bobb of Seymour was recognized for 35 years of continued membership in the American Academy of Family Physicians.

Dr. Edward L. Keppler, a Marion general surgeon, and his wife, Marla, received the first Grant County Scottish Rite Family Life Award. They were recognized for demonstrating outstand-

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

Bergman, Bernard A., Granger
Bhojraj, Deepak G., Hobart
Bisson, Kenneth A., Angola
Brumbaugh, Howard, Indianapolis
Chua, Farida I., Merrillville
Fiscus, Clifford W., Indianapolis
Glock, Hugh E., Greencastle
Gluek, Louis A., Munster
Hamilton, Thomas G., Columbia City
Harris, Charles M., Carmel
Healey, Patrick J., Carmel
Jackson, Richard W., Beech Grove
Kobak, Alfred J., Valparaiso
Kuhlman, Deborah S., Kokomo
Ladowski, Joseph S., Fort Wayne
McCormick, Charles O., Greenwood
Mehta, Dinesh B., Terre Haute
Mehta, Rajan I., Bloomington
Mehta, Shobhana D., Terre Haute

Miller, Wayne S., Fort Wayne
Mitchelson, John E., Indianapolis
Mohr, William H., Kokomo
Nale, Stephen W., New Albany
Parker, Camille K., Logansport
Patheja, Surjit S., Valparaiso
Phillips, David S., Elkhart
Royer, Carol A., South Bend
Rudolph, Kenneth J., Evansville
Sartore, Gilbert A., Evansville
Senasu, Sunchai, Valparaiso
Stewart, John C., Kokomo
Stewart, L. Ray, Evansville
Stransky, Theodore J., Evansville
Swint, Robert E., Fort Wayne
Volan, George J., Merrillville
Wenzler, Paul J., Bloomington
Wernert, John J., Indianapolis
White, John P., Bloomington
Wieschhaus, Martin F., South Bend

ing development of the family unit and for making significant contributions benefiting the family and community.

Dr. Stephen W. Perkins, an Indianapolis facial plastic surgeon, lectured to medical residents at the University of California at San Diego Naval Hospital and performed surgical demonstrations of three procedures.

Dr. Richard D. Zeph, a Carmel facial plastic and reconstructive surgeon, presented a master's seminar on tip grafting in open rhinoplasty at the fall meeting of the American Academy of Facial Plastic Surgery in Kansas City.

Several physicians from

Orthopaedics Indianapolis have given presentations. **Dr. William O. Irvine** presented a case study on the diabetic foot during a program titled "Diabetes Update 1991." **Dr. Terry R. Trammell** gave a three-part presentation related to Indy car racing during a program sponsored by Olean General Hospital and Olean Medical Group; he also talked on "The Comparison of Harrington Distraction Instrumentation to C/D Instrumentation in the Treatment of Fractures of the Thoracolumbar Spine" as part of the Garceau Wray lectures at the Indiana University School of Medicine. **Dr. Robert C. Gregori** talked on inpatient rehabilitation, Medicare

criteria and stroke rehabilitation during the annual meeting of the Indiana Society of Physical Medicine and Rehabilitation. **Dr. F.R. Brueckmann** spoke to a YMCA youth group on "Are Steroids for Kids?" **Dr. Sanford S. Kunkel** spoke to 300 orthopaedic surgeons on "ACL Reconstruction Issues in Implant Technology." **Dr. David A. Fisher** spoke on "Design Rationale for a Cemented Femoral Component" during a program on Issues in Orthopaedic Implant Technology in Marco Island, Fla. **Dr. Andrew J. Vicar** discussed "Treatment of Complex Fractures of the Distal Radius" as part of the Garceau-Wray lecture series.

Dr. Clifford Fiscus, an Indianapolis ophthalmologist, recently participated in an excimer laser workshop with Professor Theodore Seilor, M.D., one of the original investigators in the use of lasers for the correction of nearsightedness, at the Augenblick Clinic in Berlin, Germany.

Two Indiana transfusion medicine specialists have retired. **Dr. Margaret J. Ball** served as the medical director of the Fort Wayne Red Cross Blood Services since 1963 and as its executive head and chief regulatory officer since 1970. Under Dr. Ball's leadership, the blood center expanded to become one of the few U.S. blood centers with an excess of blood. **Dr. Victor H. Muller** was medical director of the Community Blood Bank of Marion County, now the Central Indiana Regional Blood Center, for 18 years. He then served as the blood bank medical director at St. Vincent Hospital.

Dr. Frederick M. Kelvin, an Indianapolis radiologist, was a panel member for a discussion on "Defecation Disorders" at the

annual meeting of the American Uro-Gynecologic Society in Newport Beach, Calif.

Dr. George Revtyak, an interventional cardiologist, has joined Indiana Heart Physicians in Indianapolis.

The following physicians received three-year appointments as Cancer Liaison Physicians: **Dr. A.E. Stouder, Jr.**, Tipton County Hospital; **Dr. John H. Seward**, Bedford Medical Center; **Dr. Hugh E. Glock**, Putnam County Hospital; **Dr. Paul W. Cronen**, King's Daughters' Hospital; **Dr. John B. Beaven**, Jasper Memorial Hospital and Health Care Center; **Dr. Panos C. Alexander**, Howard Community Hospital; and **Dr. David P. Gray**, Bartholomew County Hospital. The Cancer Liaison Program is a part of the Commission on Cancer of the American College of Surgeons. □

New ISMA members

Jitender P.S. Bhandari, M.D., Bloomington, gastroenterology.

Bradford J. Bomba Jr., M.D., Bloomington, internal medicine.

Mark R. Dagostino, M.D., South Bend, cardiovascular diseases.

Douglas E. Eglen, M.D., Kokomo, anatomic/clinical pathology.

Janet M. Fritsch, M.D., Spencer, anesthesiology.

Dwight V. Galloway, M.D., Carmel, plastic surgery.

Terrence M. Greene, M.D., Bloomington, general surgery.

Pamela S. Higgins, M.D., North Manchester, oncology.

Theodore W. Hoehn, M.D., Bloomington, emergency medicine.

James E. Holmes, M.D., Bloomington, emergency medicine.

Rakesh Kansal, M.D., Dyer, internal medicine.

Arthur H. Katz, M.D., Munster, otolaryngology.

Stephan Kowalyk, M.D., Munster, internal medicine.

Cesar M. Labitan, M.D., Valparaiso, family practice.

Carlton L. Lyons, M.D., South Bend, obstetrics and gynecology.

Mary D. Mahern, M.D., Bloomington, family practice.

Mary K. McTigue, M.D., Bloomington, dermatology.

Kunki K. Min, M.D., Munster, psychiatry.

Sherri C. Nuss, M.D., Kokomo, family practice.

Charles M. Platz, M.D., Indianapolis, family practice.

Marshall M. Poor Jr., M.D., Bloomington, neurological surgery.

Shashikant R. Rane, M.D., Hobart, internal medicine.

George E. Revtyak, M.D., Beech Grove, cardiovascular diseases.

Mark W. Rukavina, M.D., Bloomington, emergency medicine.

Alberto R. Sanchez, M.D., Highland, internal medicine.

Elizabeth B. Shelton, M.D., Jeffersonville, psychiatry.

Bruce W. Speicher, D.O., Bourbon, family practice.

Lee M. Sredzinski, M.D., McCordsville, emergency medicine.

Richard A. Stoldt, M.D., Mishawaka, oncology.

Randall S. Yessenow, M.D., Munster, plastic surgery.

Residents

Laura O'Brien Dugan, M.D., Indianapolis, diagnostic radiology.

Daniel E. Lehman, M.D., Indianapolis, orthopaedic surgery. □

■classifieds

ORTHOPAEDIC SURGEON – Immediate need for BE/BC orthopaedic surgeon in east central Indiana community of 20,000. This opportunity, in an ever-increasing sports-oriented community, is with multi-specialty clinic that has its own lab and x-ray and is skillfully managed for low overhead. The 107-bed hospital is state-of-the-art with a quality staff. Guarantee, productivity and benefits. For information, call 1-800-323-9567.

RADIOLOGY – Seven-person group is seeking an eighth radiologist with special interest in cross-sectional imaging. The Department of Radiology is expanding, is well-staffed and has all new and modern equipment. The initial salary is competitive, with a guaranteed bonus. The all-inclusive benefits are generous, with partnership potential. The excellent practice opportunity offers suburban living at its best and is located 45 minutes from downtown Chicago. For further information, please contact Peter E. Doris, M.D., Chairman, or Antigoni Kencos, M.D., Vice Chairman, Department of Radiology, St. Anthony Medical Center, Crown Point, IN 46307, (219) 757-6320.

EMERGENCY MEDICINE – Full- and part-time positions available for Indiana hospital emergency departments. Offering flexible scheduling, competitive wages and malpractice insurance. Contact Stephen R. Myron, M.D., 430 W. Votaw, Portland, IN 47371, 1-800-858-6735 or (219) 726-6327.

SPRING BREAK: BEACHFRONT – Marco Island, Fla. March 27-April 3, 1992. 2 BR, 2 BA, award-winning condo. Pool, sailing, waverunners, water sports, children's program, exercise room, Jacuzzis, racquetball, tennis, game room. Beautiful beach, great view. Golf nearby. Close to Naples, Fort Myers airport. (317) 848-0001.

OSHKOSH, WISCONSIN – Single-specialty groups are recruiting in family practice, pediatrics, ob/gyn

and cardiology. Oshkosh is an attractive community of 55,000 people, located on the shores of Lake Winnebago and in the heart of Wisconsin's beautiful Fox River Valley. Competitive financial packages. Contact Christopher Kashnig, Physician Recruiter, Mercy Medical Center, 631 Hazel St., Oshkosh, WI 54902, or call 1-800-242-5650, ext. 2430, or (414) 236-2430.

MEDCHECK IMMEDIATE CARE – New opportunities available for full- or part-time physicians in Community Hospitals Indianapolis urgent care centers. Progressive, professional staff, excellent facilities. Must be board-certified or eligible in family practice, internal medicine, emergency or pediatrics. Call Ellen Baughman, (317) 588-7554.

FAMILY PRACTITIONERS/INTERNISTS – MetroHealth, an affiliate of Methodist Hospital of Indiana, Inc., is seeking board-certified/eligible family practitioners and internists. Share the advantages of joining an established prepaid multi-specialty physician group offering an ideal blend of practice and lifestyle, paid professional liability and competitive compensation and fringe benefit packages. Our practice is located in Indianapolis, a thriving Midwest community offering a number of cultural, educational and recreational activities. For confidential consideration, submit curriculum vitae to MetroHealth Physician Recruitment, P.O. Box 1367, Indianapolis, IN 46206.

PRACTICE OPPORTUNITY – Successful independent medical examiner practice with extensive referral listings and with transition assistance and training. Available fall 1992. Call (317) 872-0534.

INTERNISTS, PEDIATRICIANS, FAMILY PRACTICE PHYSICIANS – Outstanding practice opportunity in one of the most attractive locations in the Midwest – Goshen, Ind. Located

in north central Indiana, Goshen is bordered by hundreds of sparkling lakes, great for sailing or skiing enthusiasts; numerous wooded parks; and unspoiled rolling countryside. Its proximity to South Bend, home of the University of Notre Dame, provides a wide spectrum of spectator sports, quality concerts, theater and fine dining. Goshen College embodies the community's commitment to quality education that makes its primary and secondary schools among the best in the state. A strong economy (Goshen's manufacturing employment growth was ranked 16th in the nation by American Demographics) helps ensure a quality lifestyle. A receptive medical staff supports this recruitment and will provide excellent call and coverage. For more information, call or write Rick Addis, Goshen General Hospital, P.O. Box 139, Goshen, IN 46526; hospital, 1-800-258-4321, or home, (219) 533-8311.

A CENTRAL INDIANA COMPANY providing health promotion and occupational medicine services is seeking to expand its occupational medicine program and has a position available for BC/BE occupational medicine physician or an internal medicine physician. Unique opportunity and excellent potential for growth. Please send C.V. to Physician Search, P.O. Box 44100, Indianapolis, IN 46204.

INDIANA – CARDIOLOGIST: Dynamic, two-member cardiology practice in Columbus, southern Indiana's most progressive city, seeks a BE/BC non-invasive/invasive cardiologist. Candidates for this unique opportunity will be well-versed in all non-invasive procedures, including cardiac catheterization, which are performed locally at a progressive, 325-bed regional referral center. Columbus is nationally known as the "Architectural Showplace of America." Contact Donna McMahel, 1-800-626-1857.

FAMILY PRACTICE, OB-GYN, INTERNAL MEDICINE AND URGENT CARE positions are available in a variety of settings from Central Michigan, through Illinois, Wisconsin and Nebraska, to the rolling plains of Kansas. Single or multi-specialty groups, or solo with generous call coverage, or faculty FP. Attractive guarantees and benefits. For more information, please contact our toll-free number, 1-800-243-4353, or send your C.V. to STRELCHECK & ASSOCIATES, INC., 10624 N. Port Washington Road, Mequon, WI 53092.

ARE YOU SEEKING A POSITION in neonatology, orthopaedics, dermatology, allergy, radiology, oncology, neurosurgery or rheumatology? We have positions available in Ohio, Missouri, Wisconsin and Nebraska. Attractive guarantees and benefit packages. Single- or multi-specialty groups. To discuss your practice preferences and these opportunities, please call our toll-free number, 1-800-243-4353 or send your C.V. to STRELCHECK & ASSOCIATES, INC., 10624 N. Port Washington Road, Mequon, WI 53092.

PRO-LIFE OBSTETRICS AND GYNECOLOGY group seeks a third associate for a rapidly expanding practice. Retirement of three OB/GYNs within 18 months has created a dramatic need for expansion in this specialty. Take advantage of the recreational possibilities

of nearby Michigan while enjoying the professional advantages of practice in Indiana. Call or write Jeffrey L. Cain, M.D., West Side Obstetrics & Gynecology, P.C., Elkhart, IN 46514, (219) 293-6999.

MULTIPLE AND VARIED physician practice opportunities currently exist both within and outside Indiana. Call Patti Quiring at work, (317) 841-7575, or at home, (317) 823-4746. Patti is a physician recruiter for Quiring Associates, an executive search firm headquartered in Indianapolis.

GENERAL INTERNIST - BC/BE. To join a busy five-man practice with special interest in hospital intensive care, plus consultative and primary care practice in the Indianapolis area. Will offer partnership. Reply to Box 19616, Indianapolis, IN 46219.

POSITION AVAILABLE with thriving three-clinic urgency care corporation. Practice heavily emphasizing industrial, sports medicine and wellness programs. Regular work week, no call. Assistant medical director available. Salary and benefits in six figures. Contact Dr. Dean Elzey, (219) 489-2772.

EMERGENCY MEDICINE - Terre Haute, Ind. Local multi-hospital group seeking full-time career-oriented emergency physician for position in small- and medium-

volume community hospitals. Flexible scheduling, very competitive compensation package, partnerships available. Send CV or contact William R. Grannen, Priority Health Care, P.C., 7179 Lamplite Ct., Cincinnati, OH 45244, (513) 231-0922.

EMERGENCY PHYSICIANS WANTED - For Fayette Memorial Hospital in Connersville, Ind. Will consider all physicians with emergency medicine experience. 15,000 visits/year. Fee-for-service group does its own billing. Hourly compensation based on training, experience and qualifications. Excellent fringe benefit package includes, life, health, disability and malpractice insurance plus CME allowance, ACEP and ISMA dues, pension plan and potential bonus. Contact Michael D. Bishop, M.D., FACEP, Emergency Care Physicians, 640 S. Walker St., Suite A, Bloomington, IN 47403, (812) 333-2731.

CENTRAL INDIANA - Physician-owned emergency group accepting applications for full-time, career-oriented emergency physicians. Flexible work schedules and excellent benefit package. Part-time and directorship positions also available. Send CV or contact Midwest Medical Management, Inc., 528 Turtle Creek, North Drive, Suite F-4, Indianapolis, IN 46227, (317) 783-7474. □

Are you reading this ad?

So are thousands of others. Reach more than 6,000 physicians with a display ad in INDIANA MEDICINE, the journal of the Indiana State Medical Association.

For additional information on how to place an ad, contact INDIANA MEDICINE, 322 Canal Walk, Indianapolis, IN 46202-3252, (317) 261-2060 or 1-800-969-7545.

Advertising index

American Medical Writers Association	41
Caylor-Nickel Clinic	7
Central Pharmaceuticals	31
Estridge Corporation, Paul	5
Lilly, Eli & Co.	8, 9
Lincoln National Life	Cover
Medical Communicators	10
Medical Protective	10
Memorial Health System	2
National Rural Health Association	70
Palisades Pharmaceuticals	41
Physicians' Directory	71
Physicians Insurance Co. of Indiana	Cover
G.D. Searle and Company	Cover
St. Luke's Hospital	9
University Microfilms	31
University Place	3
U.S. Air Force	70

In accepting advertising for publication, INDIANA MEDICINE has exercised reasonable precaution to ensure that only reputable, factual advertisements are included. However, we do not have facilities to make comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services, medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertisers only. Neither sanction nor endorsement of such is warranted, stated or implied by the association.

Are you moving?

If so, please send change of address to the Indiana State Medical Association, Membership Department, 322 Canal Walk, Indianapolis, IN 46202-3252, at least six weeks before you move.

Name: ☐ Home _____

Address: ☐ Office _____

City: _____

State: _____ Zip: _____ County: _____

Office phone: _____ Home phone: _____

IMPORTANT - Attach mailing label from your last copy of INDIANA MEDICINE here:

ISMA Health/Dental Insurance

Benefits available to members of the Indiana State Medical Association and their employees through expanded ISMA group sponsored health insurance.

MEDICAL PLAN A

- 365 Days of Inpatient Hospital Care
- 100% payment semi-private or hospital ward room
- 365 Days In-Hospital Medical Care
- 100% reasonable and customary allowances for surgery, maternity, general anesthesia, medical visits, radiation therapy, and other eligible inpatient hospital charges
- Unlimited Major Medical Benefits (\$100 deductible)

MEDICAL PLAN B

- Comprehensive Major Medical protection
- \$250 calendar year deductible, \$500 per family
- Stop-Loss Limit \$5,000 per person, \$10,000 per family
- PCS Card
- Includes cost-containment features
- Unlimited Maximum Benefits

MEDICAL PLAN C

- Comprehensive Major Medical protection
- \$500 calendar year deductible, \$1,000 per family
- Stop-Loss Limit \$5,000 per person, \$10,000 per family
- Unlimited Maximum Benefits

MEDICAL PLAN D

- Economical Comprehensive Major Medical protection
- \$1,000 calendar year deductible, \$2,000 per family
- Stop-Loss Limit \$5,000 per person, \$10,000 per family
- Unlimited Maximum Benefits

MEDICAL PLAN E

- Low cost Comprehensive Major Medical protection
- \$2,000 calendar year deductible, \$6,000 per family
- Stop-Loss Limit \$10,000 per person, \$30,000 per family
- Unlimited Maximum Benefits

DENTAL PLAN

- Reasonable and customary allowances for necessary care and treatment for dental health - \$50 calendar year deductible, \$100 per family
- \$1,500 maximum dental benefit per person in a calendar year paid at 80%, additional major dental paid at 50%
- \$1,000 Orthodontia Benefits paid at 50% of reasonable and customary charges

MEDICAL REIMBURSEMENT PLAN

- Tax deductible to the professional corporation

The Lincoln National Life Insurance Company is most pleased to be underwriting the Group Medical and Dental Program for the Indiana State Medical Association. Your benefit programs have been designed to provide the highest quality coverage and service at the lowest possible cost. A special claim paying unit has been established in our Fort Wayne Regional Claims Office to handle only the ISMA program. Should you have questions or problems, you may speak directly to your claim processor at 1-800-338-0363. We look forward to serving you and encourage your review of the program and services being provided.

SUPPLEMENTAL BENEFITS FOR ORGAN OR TISSUE TRANSPLANTS

- Included with all medical plans.
- Covered Transplant Procedures: This policy covers any of the following human to human organ or tissue transplants: bone marrow; heart; heart/lung; liver; cornea.
- Maximum Transplant Benefit: \$1,000,000 per lifetime per insured person for all transplant services.

For more information regarding these coverages contact:

Earl W. Williams
Professional Account Representative
11595 N. Meridian St., Suite 802
Carmel, Indiana 46032
(317) 573-6520
1-800-421-3020
(317) 573-6524 FAX

Tom Martens
Director, Health Insurance Administration
Indiana State Medical Association
322 Canal Walk
Indianapolis, Indiana 46202-3252
(317) 261-2060
1-800-969-7545 Indiana
(317) 261-2076 FAX

AFFILIATED PHYSICIANS SERVICES, INC.
1988 Agency



The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control

A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature)

Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk, therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia HR < 50/min (1.4%), AV block total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecostasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6277V

Address medical inquiries to
G.D. Searle & Co.
Medical & Scientific
Information Department
4901 Searle Parkway
Skokie, IL 60077

SEARLE

G.D. Searle & Co.
Box 5110, Chicago, IL 60680

A91CA6148T

When diet and exercise alone are not enough...



ONCE DAILY 180mg Calan SR verapamil HCl 180mg SUSTAINED-RELEASE CAPLETS

A MILD START IN MILD HYPERTENSION

Co

INDIANA MEDICINE

The Journal of the Indiana State Medical Association

March/April 1992

Vol. 85, No. 2



So, how long
have you had
AIDS?

The Interrogation

gencing

SAFE HARBOR



Smart sailors know where to seek safe harbor. For medical liability protection, Indiana physicians find safe harbor with Physicians Insurance

Company of Indiana, the company formed and owned by the Indiana State Medical Association for that purpose.



"Together, We Make The Difference"

8425 Woodfield Crossing Blvd., Suite 300 Indianapolis, IN 46240 317/469-4100 800/284-7424

M E D I C I N E

Journal of the Indiana State Medical Association
 THE FRANCIS A. COUNTRYMAN
 LIBRARY OF MEDICINE
 BOSTON, Vol. 85, No. 2

April 1992

MAR 18 1992

Features _____

Physicians avoid lawsuit 112
 Mallon, a medical malpractice
 issues in malpractice cases.

Infective 120
 by infected patients and health
 and treat people who have been
 ed disease.

One plus one equal three 124
 cal practice, all employees, includ-
 ectively and efficiently.

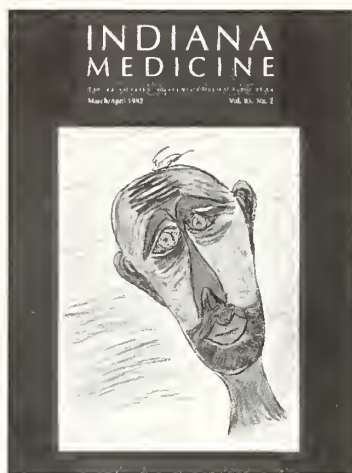
Precautions become effective 128
 on bloodborne pathogens, issued
 d Health Administration, hinges on
 precautions.

Insurance, malpractice 130
 lup Poll survey, most Indiana house-
 bred insurance through a group

..... 141

tion

cause of dyspnea 136



Cover art by Ray Gencius of
 Indianapolis. Cover design by
 Diane Alfonso of Indianapolis.
 For AIDS/HIV-related articles,
 see pages 106 and 120.

■ departments

stethoscope	104
editorial	106
letter to the editor	108
drug names	134
annual reports	146
auxiliary report	147
isma membership report	148
about the artist	149
from the museum	171
cme calendar	172
what's new	173
obituaries	174
people	176
isma leadership	179
news briefs	181
classifieds	182

al Selection

St. Luke's Healthcare Association – a progressive, multifacility healthcare system located in Saginaw, Michigan – currently has private practice and hospital career opportunities for physicians in selected areas of specialization.

The Association provides a complete range of specialty care units, including adult and pediatric intensive care, coronary care and emergency care. We recently opened The Family Birth Center™ – a progressive, new, single-room obstetrics unit. And we cooperate in an active residency program

affiliated with Michigan State University's College of Human Medicine.

St. Luke's Healthcare Association is a diverse and growing organization, anxious to meet with physicians interested in pursuing a career marked by a strong administration/physician working relationship and a team approach to patient care.

If you're such a physician, St. Luke's Healthcare Association and Saginaw, Michigan, are natural selections. Contact us today for additional information.



Call or write Jan Gould,
Physician Recruiter:
St. Luke's Hospital
700 Cooper Ave.
Saginaw, MI 48602
1-800-633-3546.



A service of St. Luke's Healthcare Association.
© 1991 St. Luke's Healthcare Association. All rights reserved.

INDIANA MEDICINE

Devoted to the interests of the medical profession and public health in Indiana since 1908.

MANAGING EDITOR

Tina Sims

EDITORIAL ASSISTANT

Toni Settle

BUSINESS MANAGER

Richard R. King

CIRCULATION

Rosanna Iler

EDITORIAL BOARD CHAIRMAN

George T. Lukemeyer, M.D.

EDITORIAL BOARD

I.E. Michael, M.D.

(Term expires Dec. 31, 1991)

Thomas J. Conway, M.D.

Robert C. Ziss, M.D.

(Terms expire Dec. 31, 1992)

James R. Buechler, M.D.

James W. Edmondson, M.D.

Robert L. Forste Jr., M.D.

George C. Manning, M.D.

Bruce F. Waller, M.D.

(Terms expire Dec. 31, 1993)

Franklin Roesner

Paul Forman

(Medical students)

CONSULTING EDITORS

Steven C. Beering, M.D.

Charles A. Bonsett, M.D.

Walter J. Daly, M.D.

Alvin J. Haley, M.D.

Rodney A. Mannion, M.D.

Alan T. Marty, M.D.

EDITOR EMERITUS

Frank B. Ramsey, M.D.

INDIANA MEDICINE (ISSN 0746-8288) is published six times a year (in January, March, May, July, September and November) by the Indiana State Medical Association. Second-class postage paid at Indianapolis, Ind., and additional mailing offices.

Address correspondence relating to editorial material, advertising or subscriptions to: INDIANA MEDICINE, 322 Canal Walk, Indianapolis, IN 46202-3252. Phone (317) 261-2060 or 1-800-257-ISMA.

Annual subscription rates for nonmembers: \$15 domestic, \$17 Canada, \$18 foreign. Medical library rates: \$14 domestic, \$15 Canada, \$16 foreign. Full-time Indiana medical students: \$7. Single copies not available. Subscriptions are renewable annually.

POSTMASTER: Send address changes to INDIANA MEDICINE, Indiana State Medical Association, c/o Membership Department, 322 Canal Walk, Indianapolis, IN 46202-3252.

Views expressed do not reflect the opinions of the editors. No copyright is claimed, unless specifically indicated. Copyright rests solely with authors, who are responsible for statements in their articles. Scientific and editorial contributions are accepted for exclusive publication, subject to editorial requirements. Instructions for authors available on request.

All issues since 1967 are available on microfilm from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, MI 48106. Indexed in *Index Medicus* and *Hospital Literature Index*.

Advertising rates and data available upon request. INDIANA MEDICINE reserves the right to accept or reject advertising.

Your Rx for Valium

(brand of diazepam/Roche)



may be open to
seventeen
interpretations...

unless you settle the issue by signing
on the "Dispense as Written" line.

VALIUM[®]
brand of
diazepam/Roche[®]

2-mg 5-mg 10-mg
scored tablets

The final choice should really be yours

The cut out "V" design is a registered trademark of Roche Products Inc.
Copyright © 1991 by Roche Products Inc. All rights reserved.

ROCHE Roche Products

Roche Products Inc.
Manati, Puerto Rico 00701

*According to the Orange Book, 10th ed, US Department of Health
and Human Services, 1990, diazepam tablets may be available from as many
as 17 companies. Tablets shown represent 5 mg diazepam tablets.

IMPAC to sponsor political leadership seminar May 13

The Indiana Medical Political Action Committee (IMPAC) will sponsor a seminar on "Political Leadership in the '90s" for physicians and their spouses. The event will be from 8:30 a.m. to noon Wednesday, May 13, at the University Place Conference Center in Indianapolis. Participants will learn techniques to help them become more effective leaders and to enable them to speak for their candidate in the medical community. Tips will be given on public speaking, writing letters to the editor and mobilizing the medical community. Each participant will receive a copy of the *AMA Political Insiders Toolbook*, which is written for the medical community. No fee will be charged, but space is limited. To register or receive more information, call Susan Grant at the ISMA, (317) 261-2060 or 1-800-257-4762 before April 24.

ISMA posts several victories in legislative session

The Indiana General Assembly concluded its 1992 "short session" Feb. 14. The ISMA Department of Government Relations will compile a summary of bills of interest to ISMA members in a *Digest of Health and Medical Laws* that will be published in a future issue of INDIANA MEDICINE. Here is the final status of some of those bills:

- House Bill 1023 – This bill would have provided for a universal health care system in Indiana, prohibiting private health insurance policies in favor of a single payor, administered by state government. The bill died in the House Ways and Means committee.
- House Bill 1182 – Entities performing utilization review will be required to register with the state department of insurance as a result of the passage of this bill. The bill mandates UR entities to provide for appeals procedures and a procedure whereby all reviews for necessity and appropriateness are reviewed by a licensed physician.
- House Bill 1220 – This bill, defeated by the ISMA, would have allowed the state worker's compensation board, composed entirely of attorneys, to implement a fee schedule for physician reimbursement under worker's compensation.
- House Bill 1337 – The passage of this bill will result in implementation of the federal requirement that state Medicaid programs implement a drug utilization review process.

OSHA lists deadlines for bloodborne pathogens regulations

The new Occupational Safety and Health Administration regulations on bloodborne pathogens took effect March 5. Strict requirements for the various stages of implementation are included. Every affected office or medical site must complete an exposure control plan by May 5, and employee education and training requirements must be in place by June 4. The remaining provisions take effect July 6. For more complete information on these new rules, see the article on page 128 of this issue of INDIANA MEDICINE. □

[illegible]

Caylor-Nickel Clinic, P.C.

1-800-552-2923 in Indiana • 1-800-348-2845 outside Indiana

Policies on HIV testing explained

George T. Lukemeyer, M.D.
Chairman, Editorial Board
INDIANA MEDICINE

After months of debate about HIV testing of health care workers, almost everyone has issued a policy. The AMA released its extensive HIV Report last December, just a month after ISMA's House of Delegates argued, sometimes hotly, whether doctors should be tested and ultimately adopted a policy that included voluntary testing of physicians who do invasive procedures. The proposed policy from the Indiana State Department of Health has been approved by the ISDH executive board and is enroute through the rule making process. It is expected to go through a public hearing this month or in April at the latest.

Similarities exist among the policies. Physicians need to know what the policies say and how to comply.

ISMA policy

Health care workers who perform exposure-prone invasive procedures should know their HIV status, according to the policy the ISMA adopted. An HIV-infected health care worker should restrict his practice to avoid exposure-prone, invasive procedures or consult with an expert review panel for advice about modifying the procedures. Media reports to the contrary, nowhere in the policy is there support of mandatory testing of physicians.

The ISMA continues to support HIV testing of patients as medically indicated without specific consent, but with general health care consent. A bill allowing for such testing, HB 1399, was introduced in the 1992 session of

the Indiana General Assembly but failed to receive a committee hearing.

ISMA members react

The ISMA has received many questions and at least a couple letters from members about its policy. Since ISMA's policy is similar to both the AMA and the ISDH policies, some physicians may disagree with all three. I am reminded of something ISMA immediate past president Dr. Michael Mellinger said in his address to the House of Delegates. He was speaking about the

American health care delivery system, but his comment can be applied to HIV. "Public opinion is rapidly approaching a critical mass" In the case of HIV, public opinion has already reached a critical mass. Public fears about iatrogenic transmission of HIV can no longer be calmed by scientific studies and statistics to the contrary.

Political reality was voiced by the *South Bend Tribune* in an editorial praising ISMA's policy. "Protecting the People" stated, "If medical professionals don't take steps themselves to assure that

Media coverage misinterprets policy

ISMA's HIV testing policy proved to be one of the most controversial issues to come before ISMA's House of Delegates in recent memory. Public fear of contracting HIV from physicians and other health care workers complicated and politicized the debate. If public concerns weren't enough, the Associated Press reported statewide that the ISMA supported mandatory testing of physicians. Those reports prompted many ISMA members to question the policy. The Associated Press did not cover the debate in the House of Delegates. Instead the wire service rewrote the news release that had been distributed by the ISMA.

Television reporters covering the House of Delegates debate failed to do much better. One Indianapolis television reporter spent considerable time listening to debate and interviewing ISMA physicians

present to get the story. However, after her lead-in that night on the news, the taped coverage of the debate gave the impression that an opponent of the proposed policy who spoke on the floor of the House was supporting the policy.

Studies continue to show immeasurably small risk of iatrogenic HIV infection. But media reports about the Kimberly Bergalis case have had a far greater impact on public opinion than science. Further evidence of the depth of public fear is ISMA's Gallup survey, conducted in August 1991. Ninety-four percent of respondents indicated that surgeons should be tested for HIV. Eighty percent said all physicians should be tested. The scientific evidence was debated, but the perceived need to respond to public fears ultimately won out as the ISMA policy developed. □

health care workers infected with the HIV virus tell their patients before performing invasive procedures, lawmakers eventually will. The Indiana State Medical Association sees wisdom in the medical profession protecting its reputation of trust." Patients who will undergo invasive procedures should be willing to be tested, the *Tribune* also noted. "Health care professionals deserve the same degree of protection from the HIV virus that patients are provided," the editorial concluded.

AMA policy

The following planks are included in the AMA recommendations:

- Health care workers observe universal precautions.
- Physicians who perform exposure-prone invasive procedures voluntarily determine their HIV status.
- HIV-positive physicians who do invasive procedures disclose their status to a local review panel that will determine practice limitations.
- Local panels monitor HIV-infected physicians for compliance with practice limitations.
- HIV-infected doctors who repeatedly violate practice limitations or precautions be reported to state licensing boards.
- HIV-infected doctors refrain from exposure-prone procedures or perform them only with permission of review panels and with patient consent.
- The AMA and insurers explore liability coverage issues for HIV-infected physicians.
- The AMA explore a volun-

tary office visitation program to assess procedures for preventing HIV/HBV transmission.

- Confidentiality of HIV-infected patients to be protected.
- The AMA educate patients on the extremely small risks of HIV transmission from health care workers.
- Further research on reducing transmission risks.
- Workers at risk of contacts with infected fluids be protected as suggested by OSHA.

The AMA recommendations reaffirm its opposition to mandatory testing. It also opposes mandatory reporting of HIV infected physicians to state licensing boards until there is conclusive evidence an infected physician poses a significant risk to patients. Planks regarding education on universal precautions and research in the risk of HIV transmission via specific surgical procedures are included in the policy.

ISDH HIV policy

The Indiana State Department of Health's (ISDH) policy emphasizes mandated education and rigorous adherence to universal precaution practices. Neither mandated HIV testing of health care workers nor of patients are included in the policy. Under the policy, patients as well as physicians would be educated on universal precautions. Like the AMA and the ISMA policies, health care workers who believe they are at risk for HIV should know their HIV status.

Under the policy, employers and facility operators will be re-

quired to post evidence that their health care workers have complied with required certified universal precautions training and education.

The ISDH policy also calls for a review panel for physicians who test positive for HIV to advise doctors how to modify their techniques or to cease them. ISDH Commissioner John C. ("Chris") Bailey, M.D., said the review panel is strictly advisory. The review panel has no policing authority and will maintain confidentiality. The rule proposes that the review panel must be sponsored by an organization approved by the ISDH. Each review panel must consist of the affected HIV positive health care worker's personal physician, an infectious disease specialist knowledgeable in the epidemiology of HIV infection, a health care provider experienced in the procedures and an infection control expert or epidemiologist.

Dr. Bailey told members of the ISMA Board of Trustees in January that administratively making changes to Indiana's HIV law to strengthen universal precaution rules was more expeditious than doing so legislatively. The legislative process would have opened up the testing issue to some of the emotional arguments that have politicized AIDS from the beginning. The goal was to bring the state into compliance with the CDC guidelines on universal precautions and to protect patients and health care workers. □

■ letter to the editor

Resolution offensive

I found Resolution 91-27 quite offensive and was surprised to see the reference committee did not file it in the trash. I think seeing this report demonstrates the value of INDIANA MEDICINE in disseminating the thoughts of members, not

to mention relaying news and information from the convention to those unable to attend each year. I must not be as highly educated as the physicians who introduced the resolution, since I find the articles informative.

Dr. Lukemeyer's editorial in

the same issue [January/February 1992] addresses evolving changes that will help more members find the time to look at INDIANA MEDICINE.

Mark Bradley, M.D.
Columbus, Ind.

Letters to the editor

INDIANA MEDICINE welcomes letters from readers. Please submit double-spaced, typed letters that are limited to 250 words and include your name and address. Letters may be edited for space, style and grammar.

Send your letters to George T. Lukemeyer, M.D., INDIANA MEDICINE, 322 Canal Walk, Indianapolis, IN 46202-3252. □

INDIANA EMERGENCY MEDICINE

For the widest variety of practice opportunities in emergency medicine, look no further than Spectrum Emergency Care. With over 450 client facilities nationwide, you're certain to find a perfect match to your personal and professional goals.

Spectrum Emergency Care offers:

- ◆ Flexible scheduling
- ◆ Occurrence-based malpractice insurance
- ◆ Administrative support
- ◆ Guaranteed fees

To learn more about the many exciting opportunities currently available in Indiana, contact Dan Fuller at 800/325-3982, ext. 7809.

SPECTRUM[®]
EMERGENCY CARE

A member of The ARA Group

ELECTRONIC

CLAIMS

S U B M I S S I O N

...

*Erica*SM

AdminaStar
Electronic Services
a division of AdminaStar, Inc.

THE **ERICA** FAMILY OF PRODUCTS
CONNECTS INDIANA **HOSPITALS**
AND **PHYSICIANS** WITH SYSTEMS
AND PEOPLE WHO CAN HELP
MANAGE YOUR OFFICE'S MOST
IMPORTANT OPERATIONS-CLAIMS,
INQUIRY AND REMITTANCE.
BETTER. FASTER. AND MORE
EFFICIENTLY.

OUR NEW CLAIMS SOFTWARE,
FASTEMC, LETS YOU BILL
HCFA 1500 AND **UB 82** CLAIMS
ON ALMOST ANY COMPUTER
PLATFORM.

**CALL TODAY FOR A
FREE DEMONSTRATION**

**THE PEOPLE WHO PRACTICALLY
INVENTED ELECTRONIC CLAIMS**

**1.800.
437.4221**



NEW INDICATION

ONLY ONE H₂-ANTAGONIST HEALS REFLUX ESOPHAGITIS AT DUODENAL ULCER DOSAGE. ONLY ONE.

Of all the H₂-receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage. Axid, **150 mg b.i.d.**, relieves heartburn in **86%** of patients after one day and **93%** after one week.¹

AXID[®]
nizatidine
150 mg b.i.d.

ACID TESTED. PATIENT PROVEN.

AXID[®]

nizatidine capsules

Brief Summary Consult the package insert for complete prescribing information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—*Pregnancy Category C*—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

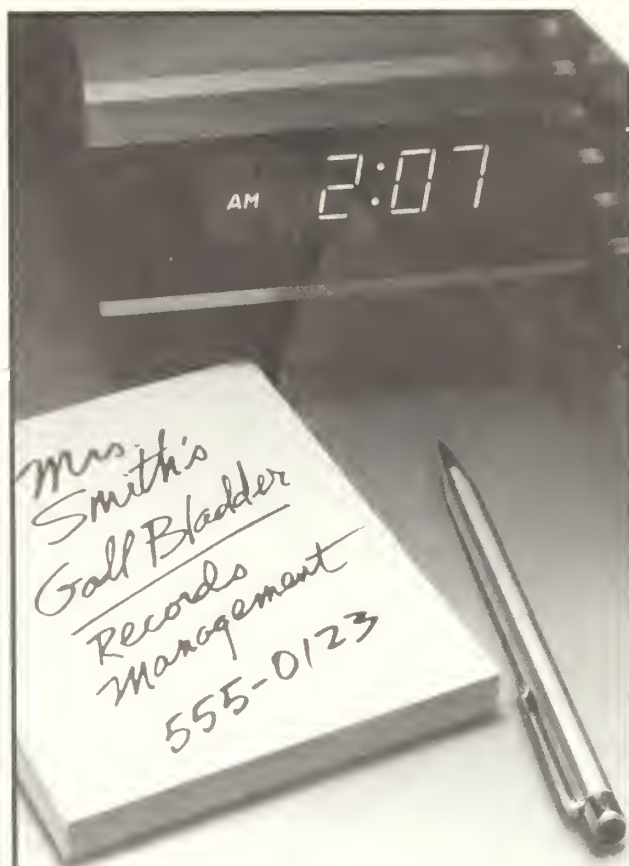
Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP [101591]

Additional information available to the profession on request.

Eli Lilly and Company
Indianapolis, Indiana
46285

NZ-2947-B-249304

© 1991, ELI LILLY AND COMPANY



If you are dedicated to health care why waste your time finding old files?

Current patient records should be at your fingertips. No question there. But what about old records, paid up bills and even dated x-rays? Consider offsite records storage. It can help clean up the office, and add to your efficiency. Your records are kept nearby in safe and secure storage facilities, for a low monthly fee. What if you need them in an emergency? With just a phone call our 24 hour, 365 day service can retrieve the needed file and fax it to you at the hospital, probably in the time it takes you to get there. Call in Records Management Services, and talk to the people that have been taking care of professional business records needs for over twenty-five years.



Records Management Services Corporation
Where business records are treated like treasure.

1165 South Girls School Road
Indianapolis, Indiana 46231
317.244.9044

Concern for patients helps physicians avoid lawsuit

"If a physician is looking to come back to general principles on what to do in a given situation, let medical care be your guiding light. That ought to be your goal, optimum care of the patient."

According to medical malpractice defense lawyer David J. Mallon Jr., this venerable principle of the healing arts is also good advice for avoiding malpractice. Indeed, the importance of



David Mallon

focusing on optimum patient care instead of thinking about a possible malpractice suit is a theme to which Mallon returned again and again in his recent conversation with INDIANA MEDICINE.

Putting the principles of good medicine into practice in today's complex and demanding health care environment, however, can challenge even the most gifted healer. Sometimes, the challenge can take the form of a medical malpractice lawsuit.

As someone who specializes in defending doctors and hospitals in medical malpractice cases, Mallon is qualified to talk with INDIANA MEDICINE about malpractice and how to avoid it. Included in this discussion are issues unique to office-based and hospital-based practices, specific do's and don'ts, what to do if you are involved in litigation, and emerging issues in malpractice cases.

Mallon is a partner in the Indianapolis law firm of Ice Miller

Donadio & Ryan. He graduated from Cornell University and received his J.D. from the Indiana University School of Law in Bloomington in 1975.

INDIANA MEDICINE: Based on your experience, can you draw a profile of a physician who is most likely to find him- or herself in malpractice difficulty? Would it be male or female, would it be just starting out, mid-career, late career? Urban or rural practitioner, primary care or specialty?

Mallon: I don't think so. To be quite honest, the one characteristic that I see in the physician cases, and this certainly does not apply to all physician cases I have defended, is the characteristic where the physician has appeared, or is perceived by the patient, not to have cared about what was going on with the patient.

It could be that the patient felt brushed off by the doctor, or the doctor just didn't come in to listen to him. That's the one thing you see, is the physician who didn't respond to the human needs of the patient, not necessarily the medical needs, but who just seemingly used bad public relations, if you will, with the patient.

[Concerning urban and rural distinctions] I think rarely do you see the family practitioner in a small town in a rural county get sued. They're still friends and they still have to keep going back to that doctor, and more often than not those doctors are perceived by the patient as to have tried, given it their best shot. If something went wrong, some-

thing went wrong.

And that goes back to my first point...the idea of treating the patients with respect and dignity and showing that you are concerned for their well-being, as much as anything, keeps you out of the courtroom.

INDIANA MEDICINE: If you were to counsel a physician on how to stay out of trouble, what would you tell that physician?

Mallon: For the rural practitioner, you've got to keep up with what's going on in medicine.

Two, you ought to have systems or structures within your office organization to keep track of the myriad of things that happen and document it. For example, the telephone practice that probably goes on invariably with every family practitioner or every pediatrician or every general practitioner, where a patient calls up and you do something. Some doctors sometimes will even prescribe over the phone; you ought to document that in the chart. I would say more often than not, you don't see it documented. The patient is going to remember that. The doctor is going to have a harder time remembering it. So document the telephone conversations on the chart.

As I mentioned earlier, have some structure in place to follow up on your lab values, your x-rays, any of your outside testing. If you send your patient out to your testing, or to have testing done, there must have been a reason for it and you ought to follow up with them because

sometimes those pieces of paper, the lab reports, or the x-ray reports get diverted and they don't get back to your office. And you can't rely on the hospital or the lab exclusively or the patient to call you up and remind you.

The other thing in a rural or a general practice that I've seen the doctors have the hardest time doing is good documentation of what they do. That may not avoid the lawsuit, but it sure makes it a lot easier to defend when it happens, if you've documented, contemporaneously with care, what the symptoms were and what you did.

And the other thing, as I mentioned before, is be up front with your patients. If something goes wrong, tell them. Don't try to hide it, don't try to avoid it. Deal with it right then, and work it out as best you can at the moment. Don't worry about getting sued so much as trying to deal with the patient at the time, and I think as a side effect that you may avoid being sued by that.

In a medical center practice or a surgical or hospital-based practice, I guess what I've seen that amazes me the most, to be honest with you, is operating on the wrong foot, arm, hand, leg. And that's an avoidable problem. You just double check.

Same thing with foreign objects left in the body. It is remarkable how often we still see cases involving foreign objects unintentionally being left in the body after a surgical procedure. It is a

false sense of security to rely solely on the counting procedure to make sure nothing is left in the body. The surgeon should still double check.

The one thing that I guess you can see in a hospital-based practice, and it certainly is an unconscious thing, is to make sure there's somebody coordinating the care when you have multiple specialists involved. If it has not been clearly established that the primary responsibility has shifted from the admitting internist to the

One way of avoiding problems is making sure somebody's trying to coordinate and monitor and not assuming somebody else is doing it.

cardiac specialist, then the potential for difficulty is there. One way of avoiding problems is making sure somebody's trying to coordinate and monitor and not assuming somebody else is doing it.

Another aspect of the same interaction is that a second or third physician should guard against being influenced too much by the initial diagnosis of the primary physician. In some cases the primary physician may start down the wrong road and lead others after him.

INDIANA MEDICINE: Nurses' notes. Have you found that in your experience to be a potential problem area?

Mallon: Yes. Because many times doctors don't read nurses' notes in the hospital. A lot of

times what's in the nursing notes is routine. You can see it yourself when you look at the patient type of information.

On the other hand, there are details in there that may or may not get passed on by the nurses during report and in turn then passed on to the doctor on rounds. I know it takes more time to glance through the nurses' notes, but I think in many circumstances it may help to read the nursing notes.

Looking at it from a defense standpoint, once the lawsuit is filed, I'll be quite candid with you, nursing notes become a very important part of the defense of a lawsuit. Because that's where the

data are recorded about what happens with regard to a patient. Many physicians' progress notes are very terse, to the point of being difficult to reconstruct, based on progress notes. So you have to go to nursing notes.

INDIANA MEDICINE: I just want to clarify that last comment. Is it the responsibility of the doctor to be aware of what's in the nursing notes?

Mallon: Yes. I think you're going to find that the rare physician who will testify in court that a doctor is not held to know what's in the information that's in the nursing notes.

And I think a jury is not forgiving of the doctor who doesn't read nurses' notes or who will say "I don't have to read the nurses' notes, the nurses have to tell me."

Because the system in the hospital, where you have three shifts of nurses, and techs and therapists and what have you all contributing data into the chart, it is impossible to believe that that's all supposed to be passed on verbally. That's not the way the system operates.

INDIANA MEDICINE: Charting prescription refills. Have you found that to be another area that has the potential to create difficulties?

Mallon: Yes it does. If somebody called in for a refill, some pain medication, or what have you, I think it's extremely important to have that documented.

The thing I think the doctor in the office-based practice needs to do is make sure the physician is involved in that decision. I think it's extremely risky for a doctor to delegate to a nurse the authority to say yes or no to a prescription refill. I

mean, there's the obvious addiction problem, but it's also important I think in many circumstances for the doctor to know that the condition has not improved at that point...and maybe something else is going on. I guess the one thing I've seen with office-based practitioners that gets them into trouble more than anything else is bad office procedures.

And I'm not talking about their diagnoses or their decisions on treatment or anything like that. I'm talking about having nurses do things with no or very little supervision by the doctor that

perhaps shouldn't be going on. The doctor ought to be more involved in the treatment and document it.

You can make sure that [for] every telephone contact, the chart's reviewed and then documented before some sort of telephone advice is given.

And it would also seem to me any time you deal with somebody over the phone you ought to have as a standard, automatic, every time, "If things get worse, come to me or go to the emergency room." And I think you ought to document that each time. Because more often than not the telephone advice is probably good, given the little information that may be given to you over the telephone. But things get worse, and people, you know, they just may not ever call back.

The current trend to doing more and more procedures on an outpatient basis creates potential problems.

The current trend to doing more and more procedures on an outpatient basis creates potential problems. Since the patient is not going to be in the hospital for observation for more than a few hours after the procedure, a telephone call to the patient on the evening of the procedure or the next day to determine the condition is a good idea. Not only would this be good medicine, but it will be well received by the patient. The call and the information learned, as well as any recommendations by the physician, should be documented in the

chart.

Patients and family members may have difficulty remembering follow-up instructions after outpatient surgery procedures or guidelines as to when the doctor should be recontacted. Some studies suggest that people forget 80% of what they hear within 24 hours.

It might be advisable to have standardized written instructions given to a patient much like many emergency rooms do at present. And both oral and written instructions should conclude with "contact me if you have any questions or something unusual happens."

INDIANA MEDICINE: Patient education ... I think that may go back to informed consent.

Mallon: That's right. The doctor who tells the patient what's going on and why is much better off, because the patient is then participating in the care. I mean he, the patient, is not waiting for someone else

to do to him, he's participating in it and has some idea why.

With regard to informed consent, we have noticed that people seem to expect to be given more information by the doctors not only as to the risks of a procedure or treatment, but also the benefits to be gained and any alternative approaches that might be available to take care of the problem.

Now how much information and how detailed the information is going to depend upon the physician's judgment on how much the patient can understand. And that's a tough decision cause

sometimes you may give too much information to someone who may not know what to do with it and then make a little bit of knowledge a dangerous thing in the hands of that patient. So it's not an easy task, an easy judgment for the physician in any given situation.

INDIANA MEDICINE: **Would your advice be somewhat different for someone who has, say, just completed his or her residency, than it would be for a doctor who's been practicing for 10 years or who may be nearing retirement?**

Mallon: Make sure you're current as you near your retirement – don't slack off on your acquisition of knowledge. And on the other end of the scale, don't assume you know everything just because you got out of residency. That kind of arrogance can get you into difficulty.

INDIANA MEDICINE: **What advice would you give to a client who is involved in litigation?**

Mallon: Don't talk about it to anyone. Whatever you say to anyone other than your lawyer, and maybe in certain circumstances representatives of your insurance company, the other side can find out about.

Anything you say to your lawyer, once the lawyer-client relationship is established, is privileged and can't be discovered or put into evidence. But if you talk to a friend at a cocktail party about your lawsuit and you say something about it and the plaintiff finds out about that, he's perfectly free to ask you what you said or ask the person to whom

you spoke what you said. And you may have made an unguarded, ill-advised statement that's incorrect that will come back to haunt you.

So my first bit of advice is you don't talk about it to anyone but me, or people in my firm. And if you want to talk about it, because people need to talk – you can't just keep it bottled up – call me. We'll talk about it. Come meet with me, we'll talk about it. But don't talk about it to your partners, don't talk about it to your colleagues in the hospital, because it can come back to haunt you.

The second bit of advice is not to let this become the most important thing in your life. Many physicians understandably take a malpractice suit as a slap in the face or a challenge to their reputation or a black mark on their reputation. Just because there has been a lawsuit doesn't mean you're a bad doctor. Just because there is a lawsuit that may even have some merit to it doesn't mean you're a bad doctor.

If you become so obsessed with the lawsuit, and you lose perspective of where that fits in to the larger scheme of things, it does the doctor no good, his family no good and his patients no good.

Three is to help us when we need the help. Don't hold back information from us. Many times you can defend a case on the know when you know all the facts. But if you go on a line of defense of a case and the doctor has held back information, the process generally gets that information out at some point along the line. And if the defense lawyer's gone too far with one

line of defense based on an assumed set of facts and then this new knowledge comes out, it can really be much more damaging than the original knowledge ever could have been.

INDIANA MEDICINE: **What are some trends or emerging issues that you're seeing in your work as a medical malpractice defense attorney here in Indiana?**

Mallon: I'm not so much sure it's a trend, but it's something that we see being claimed a lot and that is that hospitals are claimed to be negligent in the credentialing process, when they grant doctors privileges initially and then in the renewal process. And that may increase the tension between the hospital and the doctor.

The other thing that has happened in recent years, and no one's really sure where this is all going to shake out, even now, is the federal act that requires that all settlements in a malpractice case get reported to the federal clearinghouse.

INDIANA MEDICINE: **The National Practitioner Data Bank?**

Mallon: The National Practitioner Data Bank. That I see impacting physicians' willingness to settle cases because no one's sure how that information's going to be used.

The theory behind the act is primarily to catch the doctors who move from hospital to hospital, state to state, you know, the bad apples who are just one step ahead of the sheriff, or what have you, who move from California to Arizona to Indiana to wherever and get privileges, maybe even

licensing in the other state, by lying about their past malpractice history or disciplinary actions in other hospitals. And so the act was designed initially to have that information readily available to hospitals so they could check the accuracy of the doctor's application.

What is happening, however, is that the good doctors, who may have a lawsuit against them, and it's what we call a nuisance lawsuit, are saying, no, I don't want to settle that because that's going

to be reported to the data bank and I don't know what that's going to do to me in the future if I want to move to another state or if I want to go to another hospital.

INDIANA MEDICINE: Any closing thoughts?

Mallon: Just one thought, I guess. Just because a doctor gets sued doesn't mean he has failed in trying to stay out of trouble. Suits get brought even when the doctor's given good care and done

all the things that anybody might have suggested to him to do. He still gets sued. And you can't do anything to avoid that, the type of suit where you are just one of many doctors involved and you get sued with all the others because nobody can sort out who did what, or haven't taken the time to sort out who did what. □

This interview was conducted by Bob Carlson, a health care communications consultant in Indianapolis.



CREATE A MEDICAL BREAKTHROUGH.

Become an Air Force physician and find the career breakthrough you've been looking for.

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay per year

Today's Air Force provides medical breakthroughs. Find out how to qualify as a physician or physician specialist. Call

**USAF HEALTH PROFESSIONS
COLLECT
(317) 848-5830**



COMMITTED TO EXCELLENCE

*Roche
Laboratories
presents the
winners of
the 1991*



Please join us in honoring these outstanding Roche sales representatives who have distinguished themselves by a truly exceptional level of professionalism, performance and dedication to quality health care.

Throughout the year, each of these award-winning individuals has consistently exemplified the Roche Commitment to Excellence, and we're proud to invite you to share in congratulating them on their achievement.



Cynthia A. Armbruster

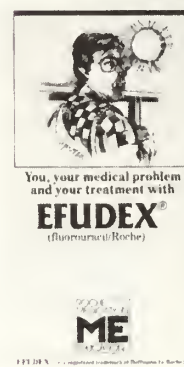
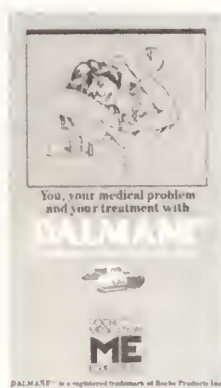
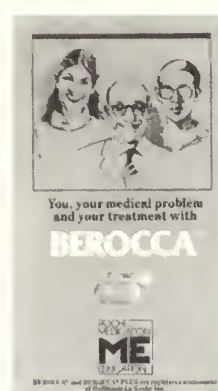
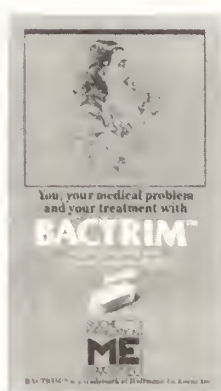


Frederick S. Ghanayem

COMMITTED TO TOTAL HEALTH CARE

*Roche
Laboratories
presents the
Resource Library
for patient
information*

ROCHE **ME** MEDICATION EDUCATION

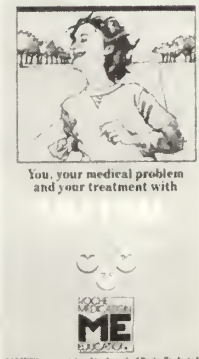
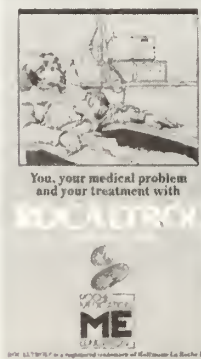
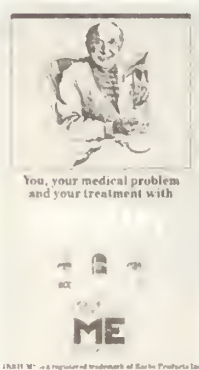


Your Roche representative offers you access – without expense or obligation – to a comprehensive library of patient information booklets designed to supplement rather than supplant your rapport with your patients.

Each booklet helps you provide...

- Reinforcement of your instructions
- Enhancement of compliance
- Satisfaction with office visits

Your Roche representative will be happy to provide a complete catalog of available booklets and complimentary supplies of those that are applicable to your practice.



FASIT W® is a registered trademark of Roche Products Inc.

LIBENTRO® is a registered trademark of Roche Products Inc.

ROCALTRON® is a registered trademark of Hoffmann-La Roche Inc.

ROCEPHIN® is a registered trademark of Hoffmann-La Roche Inc.

VALTIN® is a registered trademark of Roche Products Inc.

NO AX TO GRIND.



Our occurrence policy has been the industry standard for nearly a century. But some doctors want a claims-made policy. So we have it available. At the Medical Protective Company, we have no ax to grind. You can

choose from a variety of programs, both occurrence and claims-made, that offer greater flexibility and savings. The choice is yours. Call us today.

MEDICAL PROTECTIVE COMPANY

Vernon E. Hoover, H. Jere Frey, Michael W. Kinzer
6100 North Keystone Avenue, Suite 237, P.O. Box 20576, Indianapolis, IN 46220 • (317) 255-6525

Robert B. Newell, J. Barton Lyon
Suite 240, 2260 Lake Avenue, P.O. Box 5174, Fort Wayne, IN 46895 • (219) 422-4783

HIV provider referral proves effective

Mary Benyo
Indianapolis

Partner notification, traditionally referred to as contact tracing, involves efforts by infected patients and health authorities to locate, counsel and treat people who have been exposed to a sexually transmitted disease (STD). In keeping with the mission of public health, partner notification is a proven instrument in the protection of a general population against the proliferation of infectious disease by either unknowing or uncaring individuals.

Wrongly perceived by some as strictly a method of enforcement of state powers against those either affected or thought to be at risk of a particular disease, the public service nature of partner notification is often underestimated. When mass education, mass vaccination and official reporting programs have failed, active case-finding and contact tracing have succeeded in eradicating certain diseases.

Tracing and notification of contacts was originally proposed in the United States in 1918. The method was implemented as policy in 1937, under the guidance of Surgeon General Thomas Parran. Contact tracing has played a central role in efforts to control syphilis and gonorrhea since the early 1940s.^{1,2}

When reliable HIV antibody tests became available in 1985, routine partner notification for the control of HIV infection became possible. The immediate call for extending partner notification activities to include HIV infection

sparked heated debate.²⁻⁵ Potential advantages include targeting interventions to those at the highest risk, notifying unsuspecting female partners to prevent perinatal HIV infection, initiating early treatment of asymptomatic persons, and counseling individuals who may not be reached by other educational messages. Opponents of partner notification cite high cost, problems with confidentiality, the long incubation period of HIV, resulting in diffi-

culty locating partners, and the lack of proven efficacy.⁵ In some states, including Indiana, legislative action mandating HIV reporting and partner notification preempted this debate among public health professionals.

In July 1988, the Indiana State Legislature passed Senate Bill 9, which mandated physicians, hospitals and laboratories to report persons infected with HIV by name. In 1989, the Indiana General Assembly in Senate Enrolled

Table

Partner notification models

Patient referral

HIV positive patients are encouraged to notify partners of the possible exposure to HIV without the direct involvement of health department officials or health care providers. The health department counsels the patient on the information to be provided to the partner and the techniques for providing it.

With patient referral, health care providers may not be able to ensure that partners are actually notified or that appropriate information is given. The patient is also identified as being infected – an important consideration for any patient concerned with keeping such information confidential.

Provider referral

The health department or private health care provider is responsible for notifying the patient's partners that they have been exposed to HIV. This approach relies on the patient giving partners' names to the health department. This approach makes it possible to ensure that quality information and counseling are delivered to partners. In addition, the anonymity of the infected person is skillfully maintained.

Combination of approaches

The HIV positive patient may wish to contact one or more partners while requesting that the health care provider contact others. Here the health department follows up with the patient and assumes the responsibility for notifying partners if the patient is unsuccessful or encounters other problems.

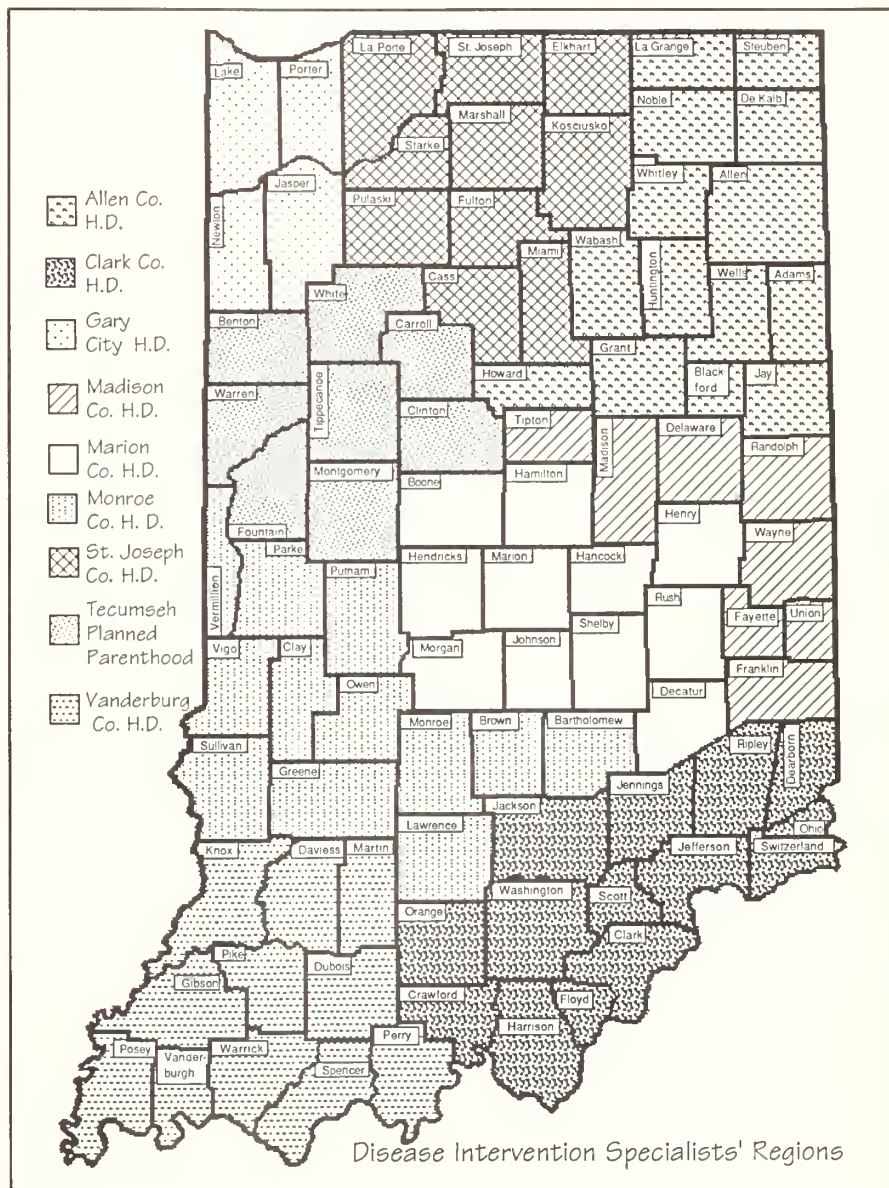
Act 429 established the requirement regarding the duty to inform all past, present and future partners of the infected individual. Under this law, the physician has the responsibility to advise the patient of his/her duty to inform, and the HIV positive patient is legally required to warn all such partners of their risk of contracting HIV and encourage the use of appropriate health care measures. Infected persons must take appropriate precautions to prevent transmission to others. Additional legislation was passed to extend the protection of patient confidentiality.

The actual notification of partners at risk is often difficult to perform. Two partner notification models provide the basis for today's HIV infection prevention and control programs: "patient referral" and "provider referral" (Table).

Provider referral

The provider referral method has a higher rate of location and notification of partners. This could have important implications. Partners who are HIV positive might have their lives prolonged by earlier therapy, and partners who are HIV negative might avoid the infection entirely by modifying their sexual behavior. The effectiveness of notification procedures is constrained, however, by the accuracy of the information provided by HIV infected patients.⁷

If provider referral is the preferred method selected by the patient, then public health authorities known as Disease Intervention Specialists (DIS) are used. DIS are fully trained in interviewing, pre- and post-test counseling, phlebotomy and the contacting of



Figure

partners in the "field" and will contact partners confidentially without disclosing the HIV positive patient's identity. Assertiveness, promptness, thoroughness and effective communication are some of the techniques used in the referral of partners.

DIS will interview HIV positive patients reported by:

- Private physicians
- Hospitals
- Clinics
- Blood banks
- State and federal correctional systems

Additionally, patients identified through confidential or anonymous testing at the state funded counseling and testing sites around the state are routinely offered this service. DIS assigned to specific regions in the state conduct the interviews with the HIV positive patients as well as with the named partners (*Figure*).

The interview: The interview includes additional post-test counseling; referral for medical follow-up and support services targeted to persons at high risk for HIV infection; and encouragement of the adoption of less-risky behavior. Patients are asked to name all sex and needle-sharing partners in the last two years. Patients are asked to identify partners back to the probable date of infection or six months before a previous negative test.

Partner identification: Counselors must ensure that partners are described thoroughly in order to expedite the process and to make certain that the correct person is notified. The partner's nickname as well as name, age, race, sex and marital status are elicited. A physical description is obtained, including approximate height, weight, hair appearance, facial hair, glasses, complexion and other visual identifying characteristics, such as scars or moles. Basic locating information includes residential address and telephone number along with landmarks and a description of the residence, since addresses frequently are incorrect.

In addition, counselors attempt to identify at least one more item of locating information to avoid delay or retracing if the basic items are flawed or don't result in a contact. Additional items include workplace, work telephone number, hangouts and the name of someone else who is familiar with the partner's whereabouts. Because this activity is a service to patients, every precaution is taken to notify named partners without placing the individual in a compromising situation. Finally, the patient is queried about any possible complicating factors, such as a partner's spouse or roommate(s), and asked

tional pre- and post-test counseling or may have their blood drawn by the DIS "in the field" at the time of notification. If the partner tests positive, the process is repeated for that person's named contacts.

Patient referral

HIV positive patients are given the option of notifying partners themselves and referring them for counseling and testing. This is known as "patient referral" or "self referral." If this option is selected, patients should be provided with the information and guidance necessary to notify partners sensitively and effectively.

The investigator will later attempt to verify that notification occurred. It has been shown that leaving the notification of partners up to the patients can

***It has been shown
that leaving the notification of partners
up to the patients can be quite ineffective
despite laws requiring that partners be notified.***

to recommend the best time and place for a confidential meeting with the exposed partner.

Extensive efforts are made to locate partners for whom reasonable identifying information is available. Priority is given to recent contacts and those not already known to be HIV positive. If the partner is in another state, an Interstate Referral Notice is sent to that state health department for notification. The HIV positive patient's name is withheld, however. Partners are notified in a face-to-face interview and counseled for 20 to 60 minutes. The identity of the infected patient is never revealed. Partners are referred to a counseling and testing site and receive addi-

be quite ineffective despite laws requiring that partners be notified. Conversely, partner notification by public health counselors has been significantly more effective.

Private health care providers

Private health care providers may elect to carry out partner notification responsibilities without involving the health department. In these cases, providers should encourage HIV infected individuals to notify their exposed partners and have appropriate HIV information packets available for positive patients to share with their partners. Such information may be obtained from state counseling and testing sites. Providers should note in the patient's chart

that the patient has been counseled to notify partners. Such a procedure is recommended as evidence of a physician's compliance with statutory requirements and also provides the basis for documentation of recalcitrant behavior. If partners are also patients of the private health care provider, the provider may inform the partners that they may be at increased risk of infection without giving any information about the source of possible infection. This should include referral services. When partners are not patients of the provider, the provider should, with the patient's knowledge, seek the assistance of the local or state health department.⁹

Partner notification by providers is generally well accepted and viewed as constructive and important by the HIV positive patients and their partners. This experience is consistent with that of Jones and colleagues⁶ in a rural county in South Carolina. They administered a questionnaire to 65% of partners more than six months after the initial notification and found that partners of HIV positive people identified wish to be informed when they have been exposed to HIV and that notification by the health department is an accepted method.

Perhaps one of the most persuasive arguments on behalf of partner notification, and one which speaks to its cost effectiveness, is contained in a study conducted by the Colorado Department of Health. This study proposed that one new infection is prevented for every two new positives identified and counseled, at a savings of \$50,000 per infection.⁴

Critics of partner notification point to the risks of confidentiality breaches and attendant liabilities, though experience in Indiana suggests that these concerns are probably overstated. For example, in the Department of Health's three-year history of HIV partner notification, there has not been a single case of such a breach. This record has been maintained through the diligent application of carefully devised procedures. During this period the program has provided the vehicle for contacting numerous high-risk individuals, and to offer available health care options to those in need. The current partner notification system – while far from a total solution – is believed to be a vital component in the state's HIV/AIDS effort.

For any questions regarding partner notification or any service provided by the State Department of Health, call the Division of Acquired Diseases, (317) 633-0851.

Physicians may also indicate requested services on the HIV Reporting Forms. □

Mary Benyo is program director of the Division of Acquired Diseases at the Indiana State Department of Health in Indianapolis.

References

1. Brandt A: Sexually transmitted disease: Shadow on the land, revisited. *Ann Intern Med*, 112:481-483, 1990.
2. Toomey KE, Cates WJ: Partner notification for the prevention of HIV infection. *AIDS*, 3:57-62, 1989.
3. CDC: Partner notification for preventing human immunodeficiency virus (HIV) infection – Colorado, Idaho, South Carolina, Virginia. *MMWR*, 37:393-396, 1988.
4. Judson FN: Partner notification for HIV control. *Hospital Practice*, Dec 15:59-69, 1990.
5. Rutherford G, Woo J: Contact tracing and the control of human immunodeficiency virus infection. *JAMA*, 259:3609-3610, 1988.
6. Jones JL, Wykoff RF, Hollis SL, Longshore ST, Gamble WB, Gunn RA: Partner acceptance of health department notification of HIV exposure, South Carolina. *JAMA*, 264:1284-1286, 1990.
7. Landis SE, Schoenbach VJ, Weber DJ, et al: Results of a randomized trial of partner notification in cases of HIV infection in North Carolina. *N Engl J Med*, 326:101-105, 1992.
8. Ramstedt K, Hallhagen G, Lundin BI, et al: Contact tracing for human immunodeficiency virus (HIV) infection. *Sex Transm Dis*, 17:37-41, 1990.
9. ASTH0, NACH0, US Conf LH0. Guide to public health practice: HIV partner notification strategies. Public Health Foundation, 1988: 1-23.

Staff development: Making one plus one equal three

John W. Kolbas, CPBC
Kathleen A. McWilliams
South Bend

Staff members are the cause of and answer to many of the problems in a professional practice. The staff is a practice's greatest asset, and a program to recruit, enhance and retain outstanding employees is critical to success.

To achieve the goals of a practice, all employees, including physicians, must interact effectively and efficiently. The entire practice suffers, as does office morale, when there are deficiencies anywhere within the practice.

Why is it important not to compromise when building a quality staff? Besides issues related to patient care, practice image and compliance with rules and regulations, it is simply more pleasurable to work with people who take pride in their efforts and are uncompromising in their commitments. Synergism exists in a quality staff. One plus one can equal three, and all parties in such an equation benefit from this synergism.

The first step in staff development is to recruit highly qualified candidates. A job description must be written for the vacant position. Finding a candidate with the necessary personality profile is an important consideration, but the person must have the necessary skills or be capable of acquiring the required skills. Practices often hire people and then build jobs around them, rather than defining the job and finding the most qualified candi-

date. Building job descriptions around people can cause inefficiencies, and important tasks may fall through the cracks.

A specific job description, mission statement and goals of the practice should be written for prospective candidates to review. A job candidate should have as much information as possible to make an informed decision. In recruiting, you are choosing a candidate, but the candidate also chooses you. Both the employer and the prospective employee should know as much as possible about each other to help ensure a long-term relationship.

Usually, the larger the pool of candidates, the more likely the highest qualified candidate will be found. To expand the pool of available candidates, practices should inform current employees, patients, local schools, hospitals and medical society placement services of the vacant position.

Newspaper ads usually are the best source for soliciting applications. The ad should provide as much information as possible about the job description to eliminate unqualified and disinterested candidates. If the practice has a personnel director, the practice's name can appear in the ad. A blind ad should be used if the practice does not have someone to answer telephone inquiries.

Requesting a resume can provide significant information about job candidates. By screening resumes, it is possible to find four or five applicants who stand out above the rest.

Conducting an interview

For a productive interview, em-

ployers should allow candidates to speak at length about current and past positions, their strengths and weaknesses and other areas providing information about personality and technical expertise. Interviewers must know what they can and cannot ask during an interview. State and federal laws are specific. Providing candidates with a written test to determine skills is an excellent way to screen candidates, but be certain you understand the Equal Employment Opportunity Commission guidelines regarding how such tests must be given and structured.

References must be checked, and the candidate should provide documentation regarding educational and/or licensure issues. One of the greatest errors practices make is not checking references. Past employers can convey a great deal of information by what they say or do not say in a telephone reference check.

As a caveat, practices should request from former employees written authorization to discuss employment history with third parties. Without written authorization, little information can be disclosed without legal risks.

Once a person is hired, the transition of the new employee into a staff requires a commitment from the entire practice. Employers often incorrectly assume that the new employee will fill the position and execute the duties effectively and efficiently. Even the simple courtesy of introducing the new employee to other staff members often is neglected. Practices must have a plan to integrate new employees into the practice.

New employees should receive office protocol manuals and personnel policy handbooks. One staff member should be assigned the job of helping the new employee feel welcome and productive.

The new employee must understand the chain of command and his or her responsibilities. Employers should explain specific

duties, deadlines and the criteria on which performance evaluations will be conducted to ensure successful integration and development of a new employee. Although many practices don't take the time for these tasks, the time that is taken today will reap rewards later.

Perhaps the greatest error in staff development, besides failing

to monitor performance, is accepting mediocrity in performance or a bad attitude from an employee. If mediocrity or a bad attitude exists, you should discuss with the employee his or her strengths and weaknesses and establish a plan and timetables for improvement. If improvement does not occur, separation will benefit both parties.

If evaluations have occurred and concern has been shown, the employee often will initiate the separation. If the employee does not resign, termination may be the best option. A staff member unable or unwilling to perform the duties of the position will alienate other members of the staff and eventually compromise the morale and team efforts of the office. Left unaddressed, even the most valued employee may grow cynical and angry about the practice's willingness to accept mediocrity. When a valued employee sees mediocrity accepted, the employee may question his or her own commitment.

Confronting an employee about lack of performance and unmet expectations is not easy. It is even more difficult to discharge an employee, but difficult decisions sometimes must be made and executed. An employee who is unable to perform the duties of the job may experience significant stress. An employee who has a poor attitude probably is unhappy in the position. Although it is difficult to lose a paycheck, the change may be a positive step in the employee's personal and professional development.

Firing an employee

When discharging an employee, many issues and laws must be considered. In many states, "at will" provisions allow an em-

Table 1
Employee recruiting

DOs

- Define position.
- Use all recruiting sources: Current staff, patients, placement services, newspaper ads, schools
- Request resumes.
- Conduct personal interviews.
- Let candidates tell you about their:
 - * Skills
 - * Ability to deal with supervisors
 - * Ability to deal with co-workers
 - * Strengths
 - * Weaknesses
 - * Last position
 - * Special interests
- Request written job application at interview.
- Consider testing.
- Provide information on mission of practice.
- Always check references.
- Notify candidates interviewed but not selected.

DON'Ts

- Don't find a person and create a job. The job description comes first.
- Don't hire a spouse.
- Don't interview just one person.
- Don't ask the following during the interview:
 - * Age or date of birth
 - * Religious affiliation
 - * Maiden name
 - * Father's surname
 - * Marital status
 - * Who resides with him/her
 - * Number of children, child care arrangements or plans to have children
 - * Place of employment of spouse or parent
 - * Whether he/she owns or rents residence
 - * If he/she has ever had wages garnished
 - * Whether he/she has ever been arrested
- Don't throw away applications of candidates not hired.

ployee to leave and an employer to discharge at any time. In other states, this provision does not exist. Even in states with "at will" provisions, there may be issues of implied contracts and other concerns that necessitate that all i's are dotted and t's are crossed before a termination occurs.

To discharge an employee, a practice must follow certain steps after the documentation is complete. The meeting to discuss the separation should occur at the end of the day, after patients and other employees have left. You may wish to have one person remain in the office, although it is not recommended that the person be a part of the separation meeting. The employee should be informed that the separation will occur and this should be communicated immediately. There should be no discussion about extending employment, but information should be provided regarding severance pay and other employee benefits that will be extended. The office keys must be returned during this meeting, and the discharged employee should gather personal belongings immediately or schedule a time to return and collect personal belongings. In either instance, someone should supervise to assure that practice records or other property is not removed.

Once a decision is made to terminate an employee, severance pay should be given, and the person should leave the practice. Arrangements where personnel are allowed to continue working for a period of time seldom work and expose the practice to significant risk.

Table 2

Terminating employees

DOs

- Keep records relative to performance reviews.
- Make the tough decision when necessary.
- Meet with employee at end of day.
- Be to the point regarding purpose of meeting.
- Help employee understand that perhaps it was the current environment or position that caused the termination and that the employee probably will be successful in a different environment or position.
- Be prepared to discuss severance pay and benefits, especially issues relating to continued health insurance coverage if COBRA applies.
- Collect keys.
- Assist employee in collecting personal belongings.
- Get written authorization to discuss employment history.
- Understand the law.

DON'Ts

- Don't change your mind.
- Don't let discussion with employee become protracted.
- Don't allow employee to remain in practice once he has been informed.
- Don't fail to discuss positives regarding employee's strengths.

Minimizing turnover

Staff turnover is costly to a practice. It takes significant time to recruit, integrate and enhance the skills of an employee; thus, once a person is a part of the team, steps should be taken to ensure that the person will remain. Taking the time to congratulate employees on jobs well done, providing competitive salary and benefit packages and creating an enjoyable office atmosphere will help assure minimum turnover.

Employees should be commended when they are doing a good job, and at times, employers should discuss an employee's deficiencies. Employees should not be disciplined in front of other employees or patients. Disciplining an employee or speaking to an employee about deficiencies in

performance requires privacy. Public displays of dissatisfaction rank as one of the best ways to destroy staff morale.

Since the health care climate in the United States is ever-changing, employees should have the chance to grow in their knowledge of the technical aspects of their own positions as well as the health care delivery system in general. Practices should promote continuing education. For example, employees who prepare insurance claims should attend seminars and read publications on reimbursement.

In practice surveys and assessments, we often find practices using old CPT books and obsolete superbills or encounter forms. Practices must stay abreast of the current changes in the practice of

medicine. For those practices that failed to convert to the new 1992 CPT codes, the cash flow crunch that they experienced may be the direct result of the failure to provide staff with current information.

Employees should be allowed to attend continuing education seminars on issues such as patient record management, patient relations, legal issues in medical office practice, collection techniques, ICD-9 and CPT coding, scheduling and personnel management. Seminars, newsletters and professional journals are an additional expense, but so are inefficiency and staff turnover. Assisting a staff member in personal and professional development sends a strong message that the practice cares.

A practice can enhance its efficiency by having open lines of communication, both horizontally and vertically. A regularly scheduled staff meeting is an effective way to improve office communication and operations. Less than 50% of the practices we surveyed hold monthly staff meetings. Even worse, a large percentage of staff indicated that staff meetings are an unproductive use of their time.

A staff meeting should have a specific agenda, written and provided to participants at least several days before the meeting. The topics to be covered should be relevant to the participants. The

participation of all parties should be encouraged by having people report on specific concerns they have with other departments and personnel. Perhaps most importantly, the practice should establish a strategic plan with specific goals and objectives, and monitor the progress to those goals and objectives during staff meetings.

Developing a quality staff requires time and effort. Since staff members have daily interactions with patients, government and third-party payors, employers, suppliers and other outside parties, the practice must devote

the necessary resources to assure the competency and commitment of the people representing the practice. □

Crowe Chizek, a CPA and consulting firm, has eight offices throughout the Midwest, serving a national client base. John Kolbas has been a medical practice consultant for the past 20 years and is the director of Crowe Chizek's Health Care Group. Kathleen McWilliams has 17 years of experience as a practice administrator and consultant, with expertise in operational concerns.

Table 3

Enhancing staff development

DOs

- Assist new staff member as he integrates into practice.
- Provide information on strategic plan and mission of practice.
- Communicate expectations.
- Conduct regular performance reviews.
- Provide competitive salary and benefits.
- Provide opportunity for continuing education in work-related and personal growth areas.
- Provide access to newsletters and professional journals.
- Encourage open communication.
- Conduct regularly scheduled staff meetings.
- Say "thank you" often.

DON'Ts

- Don't assume new staff member will know what to do or how to do it.
- Don't conduct performance reviews in public.
- Don't allow the work performance or bad attitude of a staff member to lower morale. Help the staff member improve or accept that a separation will be best for all parties.

New bloodborne pathogens rules become effective

William J. Tutwiler, J.D.
Fort Wayne

Physicians' offices will be required to develop a written exposure control plan as part of new regulations on bloodborne pathogens issued by the Occupational Safety and Health Administration (OSHA).

The Bloodborne Pathogens Standards, which were published in the *Federal Register* Dec. 6 and became effective March 6, are expected to reduce on-the-job risks for employees and prevent more than 9,200 infections and 200 deaths per year.

Exposure control plans must be completed by May 5, and employee education and training requirements under the new rules must be in place by June 4. Taking effect July 6 are the remaining provisions of the regulation, which include engineering and workplace controls, personal protective equipment, housekeeping, special provisions covering HIV and HBV research laboratories and production facilities, hepatitis-B vaccinations, post-exposure evaluations and follow-up and labeling and sign requirements.

Compliance with the new rules hinges on mandating the use of universal precautions. Handwashing upon exposure to blood or other potentially infectious fluids is stressed.

Recapping needles or removing them from disposable syringes by hand is prohibited unless the employer shows there is no alternative, in which event recapping or removal has to be done with a mechanical device or one-handed technique.

The rule covers all employees who could be "reasonably anticipated" as a result of performing their jobs to come in contact with blood and other potentially infectious materials. Such materials include semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid,

required to identify in writing tasks, procedures and job classifications where occupational exposure to blood is expected to occur, regardless of whether personal protective clothing or equipment is provided or available. Such an exposure control plan must also outline a schedule for implementing the provisions set forth in the standard and specifying the procedure for evaluating exposure incidents. The plan must be available to employees and the Indiana Occupational Safety and Health Administration (IOSHA) and be updated at least once annually.²

The regulations also require employers to provide and employees to use, at no cost, "appropriate personal protective equipment such as gloves, gowns, masks, mouthpieces and resuscitation bags." Also mandated is a "written sched-

The regulations also require employers to provide and employees to use, at no cost, "appropriate personal protective equipment such as gloves, gowns, masks, mouthpieces and resuscitation bags."

ule for cleaning, identifying the method of decontamination to be used" and specifying disposal methods.³

Health care employers will be required to make "available to all employees who have occupational exposure to blood within 10 working days of assignment, at no cost," a vaccination for the hepatitis-B virus. Any employee who declines such a vaccination must do so in writing.⁴

The regulations specify procedures that must be "made available to all employees who have had an exposure incident" and

saliva in dental procedures, any fluid visibly contaminated with blood and all body fluids in situations "where it is difficult or impossible to differentiate between body fluids." This includes any unfixed tissue or organ other than intact skin from a human being, living or dead, and HIV-containing cell or tissue cultures, organ cultures and HIV or hepatitis-B-containing culture medium or other solutions as well as blood, organs and tissues from experimental animals infected with HIV or hepatitis-B.¹

Health care employers are

required to identify in writing tasks, procedures and job classifications where occupational exposure to blood is expected to occur, regardless of whether personal protective clothing or equipment is provided or available. Such an exposure control plan must also outline a schedule for implementing the provisions set forth in the standard and specifying the procedure for evaluating exposure incidents. The plan must be available to employees and the Indiana Occupational Safety and Health Administration (IOSHA) and be updated at least once annually.²

The regulations also require employers to provide and employees to use, at no cost, "appropriate personal protective equipment such as gloves, gowns, masks, mouthpieces and resuscitation bags." Also mandated is a "written sched-

require lab tests to be conducted by an accredited laboratory at no cost to the employee. The follow-up must include "a confidential medical evaluation detailing the incident of exposure as well as all post-exposure evaluation and follow-up treatment."⁵

Hazard communication compliance requires "warning labels including the orange or orange-red biohazard symbol" to be attached to all containers of infectious materials and to refrigerators and freezers in which such materials are stored or transported. Employers may use red bags or containers instead of labeling.

Employers must provide training, initially upon assignment of an employee to such an area and at least annually for employees who have already received their initial training. The training must include a copy of the regulatory text of the standard, an explanation of its contents, a general discussion on bloodborne diseases and their transmission, a copy of the exposure control plan, engineering and work practice controls, personal protective equipment, the hepatitis-B vaccine, information on how to respond to emergencies involving blood and how to handle exposure incidents, the post-exposure evaluation and follow-up program. A question-and-answer opportunity must be given, and the trainer must be knowledgeable about the subject.⁶

Extensive medical records must be kept for any employee with occupational exposure for "the duration of employment plus 30 years." Such documents must be confidential and must be made available to the subject employee, anyone bearing that employee's written consent and IOSHA.⁷

IOSHA's Bureau of Safety, Education and Training is available to assist employers in developing and implementing effective workplace safety and health programs.⁸ A wide range of consultation assistance is available from IOSHA at no cost to employers. Consultants will assist in identifying and correcting specific hazards, developing and implementing effective workplace safety and health programs and providing training and education services. Such services are primarily developed for smaller employers with more hazardous operations. Employers must commit to correct any serious job safety and health hazards identified by the consultant. Possible violations of OSHA standards will not be reported to the IOSHA enforcement staff unless the employer fails or refuses to eliminate or control worker exposure to any identified serious hazards or unless an imminent dangerous situation exists. Employers who receive comprehensive consultation visits, correct all the hazards identified and demonstrate an effective safety and health program will be exempt from IOSHA's general schedule enforcement inspections, except for complaint or accident investigations, for one year.⁹

Civil penalties could range from \$7,000 for "innocent" violations to \$70,000 for "knowingly" or "repeatedly" violating the regulations.¹⁰

A copy of the "Occupational Exposure to Bloodborne Pathogen" regulations may be obtained by calling the IOSHA, Bureau of Safety, Education and Training at (317) 232-2688. □

The author is an attorney with the Fort Wayne law firm of Beers,

AMA offers training kit on new rules

The American Medical Association has developed a comprehensive training program to help physicians, clinics and hospitals comply with the new regulations on bloodborne pathogens.

For Your Protection: The OSHA Regulations on Bloodborne Pathogens is a complete training program that includes a 25-minute videotape, an administrator's guide, a model exposure control plan and training manuals. The videotape covers the relevant portions of the OSHA standards as they apply to most health care facilities for the purpose of training employees.

The ISMA has ordered a kit, which ISMA's general counsel will review to answer questions from members about the new regulations. □

Mallers, Backs and Salin.

References

1. Fact Sheet: *OSHA Bloodborne Pathogens Final Standard, Summary of Key Provisions*, page 1.
2. Id.
3. Id. at 1-2.
4. Id. at 2.
5. Id. at 2.
6. Id. at page 3.
7. Id. at page 3-4.
8. *All About OSHA*, U.S. Department of Labor, Occupational Safety and Health Administration Publication OSHA 2056, page 30, 1991.
9. Id. at 30-31.
10. I.C. 22-8-1.1-27.1(a).

Indiana residents polled on insurance, malpractice

One of the most perplexing problems in health care is what to do about the more than 30 million persons nationwide who are uninsured or underinsured. The Indiana State Medical Association in its survey conducted in August 1991 by the Gallup Organization of Princeton, N.J., asked several insurance-related questions of the 1,010 adult heads of household polled. The objective of the questions was to assess the insurance coverage profile of Hoosier households and determine how it compared to Gallup national data from a survey conducted in May 1990.

In preparing for its public education campaign on the Indiana Compensation Act for Patients, the ISMA devoted several questions on the Gallup survey to malpractice issues. News reports had been critical of the cap on awards and had tied malpractice to physician discipline. The survey sought to determine public perception of the cap and physician discipline.

This article represents partial results of the poll.

Insurance

Most Indiana households (61%) maintain employer-sponsored insurance through a group plan. Nationally, Gallup's study of adults indicated 52% had employer-sponsored insurance. Nearly twice the proportion of Indiana households are insured through Medicare or Medicaid (13%) as was found in Gallup's national study of adults (7%). Six percent of Indiana respondents have no health insurance, the

same percentages in Gallup's national survey.

Respondents who indicated they maintained insurance other than Medicare/Medicaid or CHAMPUS were asked:

Is that plan a traditional insurance plan, an HMO or a PPO?

Nearly three-fifths (57%) of non-Medicare, Medicaid or CHAMPUS plans were reported to be "traditional" policies, while nearly one-quarter (23%) were managed care programs, either HMOs (15%) or PPOs (8%).

The combined results of the survey questions asked on insurance indicate that 11% of Indiana households maintain insurance through an HMO, and an additional 7% maintain coverage through a PPO.

Survey participants were read a series of statements about health insurance and responded whether they agreed, disagreed, strongly agreed or strongly disagreed with the statements.

Indiana households are significantly less likely to feel that employers have responsibility to provide health insurance for dependents of employees than for employees themselves. Eighty-nine percent agreed that employers should be required to provide basic health insurance to their employees as compared to 78% who said employers should be required to provide health insurance to the dependents of employees.

Three of 10 respondents (30%) disagreed that insurance companies should be required to cover certain services such as mental

Gallup conducts survey for ISMA

The Indiana State Medical Association contracted with The Gallup Organization, Inc. of Princeton, N.J., to conduct a statewide assessment of Indiana households regarding attitudes and behaviors toward health care services and issues. Telephone interviews of 1,010 randomly selected adult heads of households were conducted in August 1991.

At the 91% level of confidence, the maximum expected error range for a sample of 1,010 respondents is $\pm 3.1\%$. Data were analyzed across key demographics including respondent age, race and geographic location. In addition, counties were classified as urban, rural or "mixed" (those in which a substantial metropolitan area was set in an overall rural area). □

health, chiropractic services, and treatment of infertility. Sixty-four percent said the government should require such coverage by insurance companies.

Malpractice and physician discipline issues

This section of the Gallup/ISMA survey examined the incidence of physician relationships, the perceived responsibility for monitoring and disciplining physicians, and the aggressiveness with

which physicians discipline other physicians. Probable reaction to impropriety on the part of the physician was examined as was consumers' experience with inappropriate physician behavior. Perceptions with regard to responsibility for increases in the amounts awarded in malpractice suits and appropriateness of the limits set on such awards were also examined. Finally, respondents were asked to rate their level of agreement with selected statements regarding malpractice suits.

Survey participants were asked the following questions:

Does your household maintain a relationship with a physician who could be called your family doctor? Do you have a personal physician who takes care of your medical needs?

Nine of 10 Indiana households reported maintaining a relationship with a family or personal physician (91%). This proportion was somewhat higher than found nationally by Gallup (87%).

Who do you feel is primarily responsible to monitor the quality of care provided by physicians and to discipline physicians who don't meet certain ethical and professional standards?

Nearly three in 10 respondents (29%) felt the state government or health department was responsible for monitoring the quality of physician care and for disciplining physicians. One in six (17%) felt that physicians should monitor and discipline themselves. Hospitals and the American Medical Association

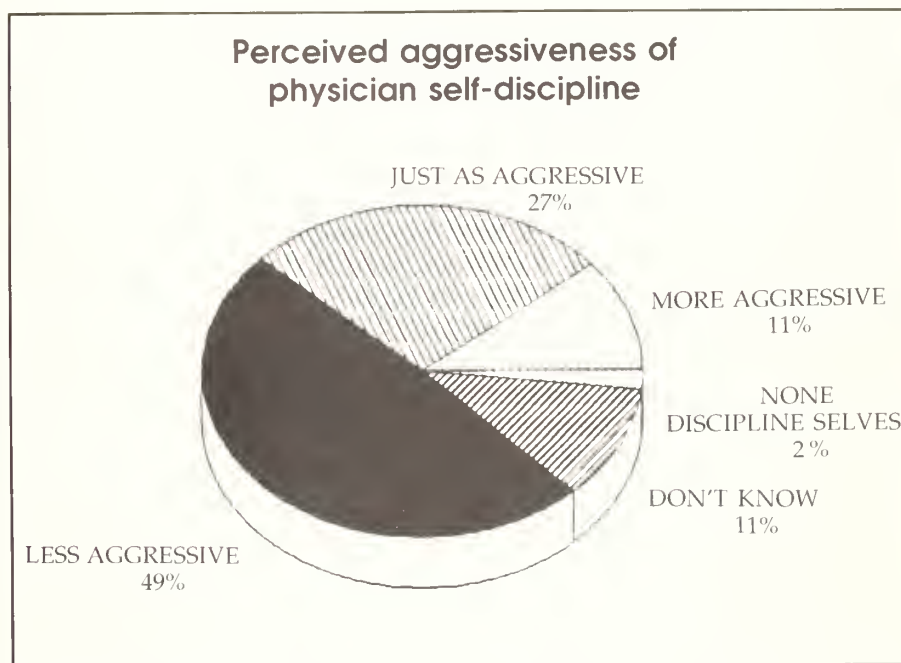


Figure 1

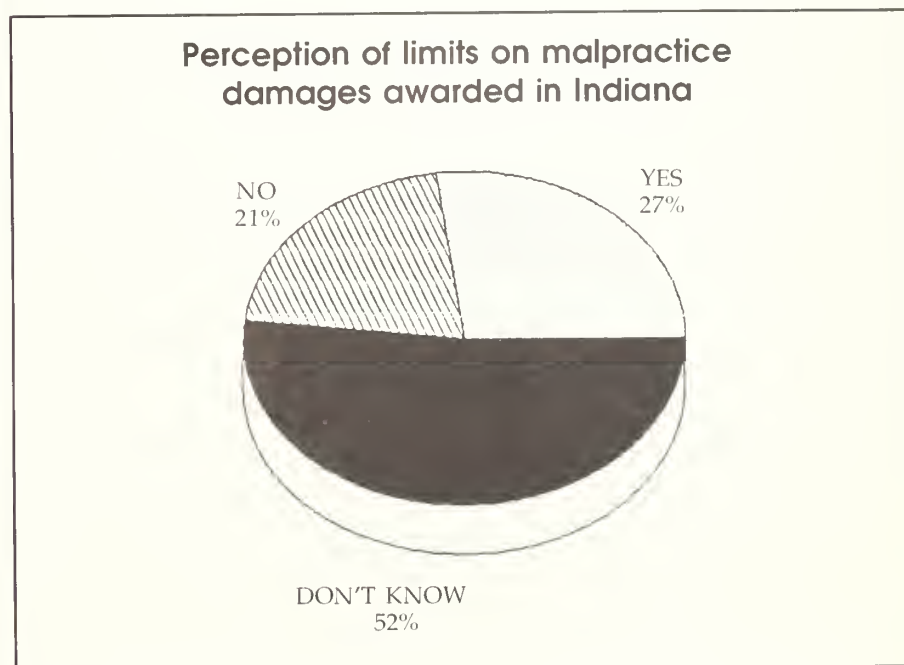


Figure 2

Opinions regarding limits on damages awarded in malpractice suits

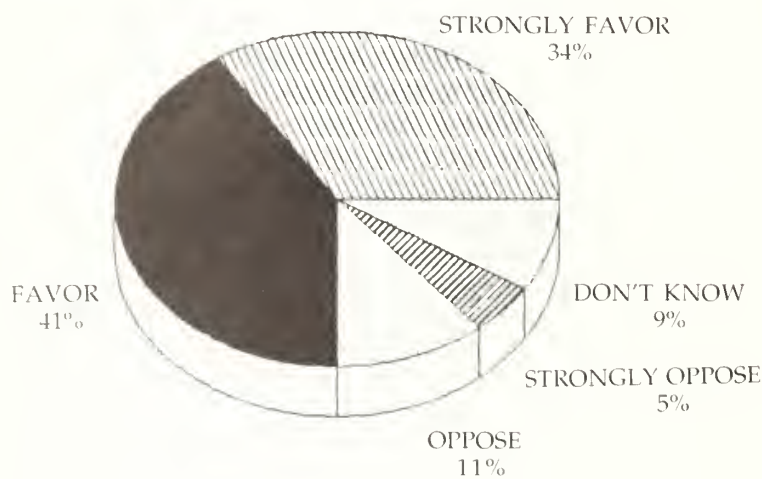


Figure 3

were each named by 6% of respondents. "Their patients/the 'market'" was the response given by 9%. Insurance companies, the federal government, government (non-specific) and medical boards were each named by 2%. Nineteen percent responded "don't know."

Do you think physicians are more aggressive, just as aggressive or less aggressive in disciplining physicians who fail to meet certain standards of care as are other professional groups such as lawyers and accountants? (Figure 1)

Nearly one-half (49%) of Indiana residents felt that physicians are less aggressive in disciplining other physicians than are other professional groups. This perception was somewhat more likely

among middle-aged respondents (age 35-54) and higher income respondents (annual incomes of \$40,000 or more).

If a physician did something or was giving you medical treatment or advice that you thought was inappropriate, what would you do?

One-half (51%) of respondents indicated that if a physician gave inappropriate medical treatment or advice, they would most likely see another physician or get a second opinion on the matter. One-quarter (26%) indicated they would confront the physician directly and ask for an explanation. Change or switch doctors was the response indicated by 13%. One in 20 (5%) indicated they would report the physician or consider suing. Younger re-

spondents were somewhat more likely to see another physician, while older respondents were somewhat more likely than younger ones to confront the physician.

Have you ever felt that you have been given inappropriate medical advice or treatment by a physician, or that a physician may have been negligent in the way you were treated or handled? What did you do?

More than one-third (37%) of respondents indicated they had at some time been treated inappropriately or negligently by a physician. Most frequently, those individuals (20%) responded to the physician by changing physicians. Sixty-two percent said they had not experienced inappropriate medical advice or treatment or felt that a physician may have been negligent.

To determine the responsibility for increased lawsuits and cash judgments, respondents were asked:

You may have read or heard about medical malpractice lawsuits against physicians and the amount of the awards being given to people by judges and juries. Who or what do you think is the main cause for the increase in malpractice lawsuits and in the size of cash judgments awarded to those who sue?

Three of 10 Indiana residents (30%) feel lawyers' greed is the main cause for the increase in the number of lawsuits and the size of cash judgments. An additional one-fifth (20%) indicated the increase is due to greed or selfishness on the part of those who file

suit. Fifteen percent named incompetent uncaring physicians and nurses as being responsible for the increase in lawsuits. "Lack of restraint by judges/juries" was cited by 7%. Another 7% said "everyone wants to sue."

The proportion of those who named lawyers' greed increased with education and household income and was highest among middle-aged respondents. Nearly one-half (47%) of Fort Wayne area residents named attorney greed, a significantly higher proportion compared to the state as a whole.

Do you think Indiana has limits on damages that can be awarded to people who sue for medical malpractice? (Figure 2)

Just over one-quarter of respondents were aware of Indiana's limit on damages awarded in malpractice lawsuits. Awareness was highest among high income respondents (\$65,000 or more) and residents of the Indianapolis and Gary/Hammond areas.

Do you think Indiana should have limits on damages that could be awarded to people who sue for medical malpractice? Would you favor or oppose such limits on medical malpractice suits? (Figure 3)

Three-quarters of respondents favor having limits on damages awarded in malpractice lawsuits. The proportion who favor such a limit was found to be highest among retirement age respondents, those with incomes of \$65,000 or more and college graduates.

Respondents were next informed that Indiana does have

Opinions regarding limits on amount of money awarded in malpractice suits

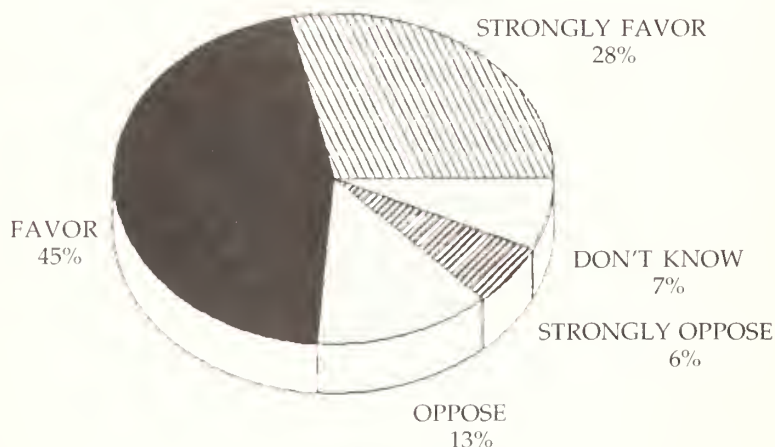


Figure 4

Opinions regarding current Indiana limit on amount awarded in malpractice suits

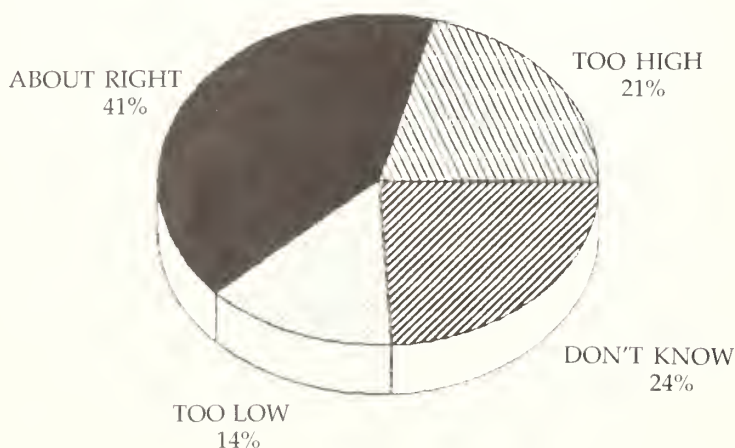


Figure 5

such limits and were asked whether they favor or oppose such limits. Again nearly three-quarters (73%) of Indiana residents indicated they favor limits on the amount awarded in malpractice suits, while one-fifth (19%) opposed such limits (*Figure 4*). Respondents age 65 or older, higher-incomed respondents, college graduates and Evansville-area respondents were most in favor of such limits.

The limit in Indiana is currently \$750,000. Do you feel that amount is too high, about right, or too low? (*Figure 5*)

After being told the limit, two-fifths (41%) of respondents indicated the current Indiana limit on malpractice lawsuits was "about right." One-fifth felt the amount was too high, while 14% felt the amount was too low. Respondents over age 65 and residents of the Fort Wayne area were considerably more likely than others to rate the current level as being too high.

Survey participants were read a series of statements regarding malpractice suits and were asked if they strongly agreed, agreed, disagreed or strongly disagreed.

An overwhelming majority of respondents (92%) agreed that the

amount lawyers can be paid from a malpractice suit should be limited. Three-quarters of the respondents (75%) agreed that limits on the amount awarded in suits would help hold down the cost of malpractice insurance for physicians, and 72% agreed that such limits help reduce the total amount of money awarded in malpractice lawsuits.

More than one-half (52%) of Indiana residents disagreed that almost every physician gets sued for malpractice at some time in their career. Forty-eight percent agreed that most people who sue for malpractice are just greedy and want some easy money, as compared to 46% who disagreed. □

■ drug names

Look-alike and sound-alike drug names

	CARDIOLITE	CARDILATE
Category:	Imaging agent	Anti-anginal agent
Brand name:	Cardiolite, DuPont Merck	Cardilate, BW
Generic name:	Technetium Tc99m Sestamibi	Erythrityl tetranitrate
Dosage forms:	Injection	Tablets
	LARYLGAN	AURALGAN
Category:	Throat product	Ear product
Brand name:	Larylgan, Ayerst	Auralgan, Ayerst
Generic name:	Combination drug	Combination drug
Dosage forms:	Spray	Ear solution

Benjamin Teplitsky, R. Ph.
Brooklyn, N.Y.

Look-alike and sound-alike drug names can be misinterpreted by a nurse reading doctors' orders or by a pharmacist compounding physicians' prescriptions.

Such misunderstandings can result in the administration of a drug not intended by the prescriber. Awareness of such look-alike and sound-alike drug names can reduce potential errors. □



ARNETT CLINIC

Lafayette, Indiana

About the Multispecialty Medical Group

Arnett Clinic has served Tippecanoe County and surrounding counties in Mid-North Central Indiana since 1922. Arnett physicians introduced the area's first dialysis service, performed the area's first open heart surgery, and developed the community's first heart catheterization laboratory. In four outpatient facilities, over 85 specialists and subspecialists provide medical and surgical services in virtually every specialty field. The bulk of Arnett's referral patients reside within a fourteen-county area surrounding Lafayette, Indiana, with a drawing area of over 300,000 people.

Ambulatory walk-in clinics in Lafayette and West Lafayette supplement primary clinic services. Arnett Urgent Care Centers are open from 8 a.m. until 8 p.m. every day, and staff members provide diagnosis and treatment for any medical problem which does not require ambulance transport.

Arnett physicians provide hospital support services at two nearby community hospitals, Home Hospital with 365 beds, and St. Elizabeth Hospital with 375 beds. Arnett has diversified into other healthcare fields, including Arnett Health Systems (an HMO) and the corporate affiliates of Arnett Medical Supply and Arnett Pharmacy.

Opportunities

The Arnett Clinic is currently seeking BE/BC candidates: Non-invasive Cardiology, Dermatology, General Internal Medicine, OB/GYN, Orthopaedics, Pediatrics, Urology.

Practice Setting

At this time, over 85 physicians work for Arnett Clinic. One of the most practical reasons for affiliation with Arnett is the availability of ancillary staff to support clinic operations. Administrative, Laboratory, and Radiology services are available on-site, making our practice environment an integrated, comprehensive, and convenient healthcare resource center. The patient base in Lafayette stems from a balanced mix of industrial and university communities. We are an equal opportunity employer.

Benefits

Our Medical Staff members enjoy competitive salaries and a generous benefit package. During the first two years of employment, Arnett offers a guaranteed minimum salary with a production bonus. After two years of successful practice experience, shareholder status with a productivity incentive formula is available. An excellent profit-sharing and investment plan is also available.

Other benefits include health coverage via Arnett HMO or other group insurance, disability, and life insurance plans. A generous fund for continuing education is available to clinic physicians.

Community

Lafayette, Indiana is a thriving, low-crime community located in a county of approximately 132,000 people. Purdue University, known for academic leadership in the areas of engineering, agriculture, humanities, and sciences, and for Big Ten Sports, is nearby. *Money Magazine* recently identified Lafayette as one of the top 14 cities in which to live in the U.S.A.

For more information, please contact:

John C. Horner
Director of Physician Recruitment
Arnett Clinic
2600 Greenbush Street
Lafayette, IN 47904
(317) 448-8000
Toll Free Nationwide, 1-800-899-8448

Coronary-subclavian steal as a cause of dyspnea

David L. Blemker, M.D.
James A. Trippi, M.D.

After successful coronary artery bypass surgery, dyspnea frequently is encountered. Dyspnea in this setting has causes including coexistent chronic obstructive pulmonary disease, pulmonary embolus, anemia, pericardial tamponade, pericardial constriction, congestive heart failure or angina equivalent dyspnea. This unusual case of coronary-subclavian steal adds an additional diagnostic consideration when evaluating dyspnea in a patient who has recovered from coronary bypass surgery.

A 66-year-old woman was admitted because of an episode of squeezing substernal chest pain radiating down her left arm that was unrelieved by sublingual nitroglycerine. She also experienced dyspnea on exertion and easy fatigability.

The symptoms of dyspnea began soon after her coronary bypass surgery was performed three years before this admission. Her dyspnea had been progressive over the four to five months before admission so she could walk only a few steps without needing to stop to catch her breath. Before this admission, she had used sublingual nitroglycerine for angina symptoms only on rare occasions. Acute myocardial infarction was ruled out with serial creatine kinase enzyme deter-

minations and electrocardiograms.

Her history was significant for coronary artery bypass grafting three years earlier, with reversed saphenous aortocoronary vein grafts to the right posterior descending and left circumflex arteries and an internal mammary artery graft to the left anterior descending artery.

At the time of bypass surgery, the blood pressure in both of her arms was 120/80 mm Hg. The postoperative period was complicated by a prolonged episode of pericarditis and by recurrent pericardial effusions requiring oral steroid therapy. Left ventricular function postoperatively was normal.

Current physical examination was remarkable for a blood pressure of 160/90 mm Hg and 90/60 mm Hg in the right and left arms respectively. There was a right carotid bruit and a diminished left carotid pulse without bruit. No jugular venous distention was noted. The lung fields were clear, and cardiac exam revealed a normal first heart sound with a physiologically split second heart sound and no murmurs or gallops were appreciated. The rest of the patient's examination was normal for her age.

The differential diagnosis included progression of her coronary artery disease, worsening left ventricular function and congestive heart failure or pericardial constriction secondary to her prolonged postoperative pericarditis.

Because her exercise was severely limited by her dyspnea, an intravenous dipyridamole thallium scan with upper extremity isometric exercise was performed and revealed a low anterior wall defect with little reversibility upon redistribution.

Catheterization of the right and left sides of the heart was performed to evaluate for sources



Figure 1: Angiogram of the left coronary artery demonstrating retrograde flow into the left internal mammary artery with contrast also noted flowing into the left subclavian artery.

of the patient's dyspnea and angina. No equalization of cardiac diastolic pressures or right ventricular dip and plateau waveforms was found. The left ventricle demonstrated mild inferobasilar hypokinesis. The right coronary vein graft was patent with the native right coronary occluded proximally. The native circumflex artery and the circumflex vein graft were both occluded proximally.

There was a 90% stenosis of the left anterior descending artery proximally, and retrograde flow of contrast was noted from this artery up the left internal mammary artery graft and into the left subclavian artery (Figure 1). The left subclavian artery was completely occluded just after its origin from the aortic arch. Digital subtraction arch aortography confirmed the left subclavian occlusion (Figure 2).

A left carotid to left subclavian bypass was performed using a Goretex conduit without complication. Her recovery was uneventful, and at one month post-operative follow-up, a repeat dipyridamole arm crank thallium scan continued to show a fixed anterior wall defect. However, she was asymptomatic and free of exertional symptoms of fatigue and dyspnea and free of angina. There was no longer a difference in blood pressure between the upper extremities.

The left internal mammary artery is now commonly used as a conduit for coronary artery bypass grafting. The great advantage of the internal mammary artery as a bypass graft is its outstanding long-term patency rate. In spite of this advantage, a previously reported but infrequent complication of this procedure is occlusion of the left subclavian artery proxi-



Figure 2: Digital subtraction arch aortogram showing a totally occluded left subclavian just distal to its origin.

mal to the origin of the left internal mammary artery.^{1-6,8-10} With subclavian artery obstruction or occlusion, reversal of flow in the graft from the coronary anastomosis to the axillary artery causes a coronary artery steal. One author reports the incidence of this obstruction in patients post-bypass surgery to be 0.4%.⁹ A related steal through an internal mammary artery graft to an intact high intercostal artery that was not ligated at the time of original bypass resulting in anginal symptoms also has been described.⁷

The presentations have varied from asymptomatic cases⁹ or stenosis found at autopsy¹⁰ to patients with symptoms of exertional and rest angina.¹⁻⁸ One case report describes a patient who developed profound shock and intractable arrhythmias while being taken off pump following placement of both left and right internal mammary artery grafts.¹⁰ This patient apparently had acute

occlusion of the right innominate artery caused by tightening of the purse-string suture as the aortic bypass cannula was removed. The resultant myocardial ischemia caused by the acute coronary steal resulted in the intractable arrhythmias and the patient's death. Our patient is of interest since she had minimal symptoms of angina at presentation and was mainly troubled by progressive exertional fatigue and dyspnea.

This case illustrates the importance of confirming the patency of the left subclavian artery before bypass surgery. Some authors have suggested routine pre-operative arch aortograms on all patients undergoing coronary artery bypass grafting.^{8,9} This procedure does not seem practical for all patients who undergo bypass using an internal mammary graft. However, subclavian stenosis or occlusion should be suspected in all patients with decreased pulses in the left arm, a systolic blood

pressure in the right arm that is 20 mm to 30 mm higher than that in the left arm or symptoms of left upper extremity claudication. These symptoms should prompt pre-operative evaluation of the left subclavian artery if a left internal mammary artery graft is being considered.^{1,3-6,10} If proximal subclavian stenosis is found, the left internal mammary can still be used as a free aortocoronary bypass graft.¹

If subclavian stenosis occurs after the time of bypass surgery, as in this case, the preferred operative repair is left carotid to left subclavian bypass using synthetic material as a conduit. Anesthetic considerations during this repair were addressed by Martin and Rock.²

This case illustrates a rare and interesting cause of dyspnea in a patient post-coronary bypass surgery. Coronary-subclavian steal is an infrequent complication of the use of the left internal mammary as a bypass graft, but this complication can be expected more frequently as more internal mammary arteries are being used for coronary revascularization. Pre-operative screening for left subclavian artery stenosis is prudent

when differential blood pressures in the arms are noted or symptoms of left upper extremity claudication exist. Surgical correction through ipsilateral carotid to subclavian bypass is the preferred treatment of choice.

This case illustrates another cause of dyspnea in patients who have successfully recovered from coronary bypass surgery, and coronary-subclavian steal should be considered in the differential diagnosis of dyspnea in this setting. ┘

Correspondence: James A. Trippi, M.D., 3171 N. Meridian St., Suite 200, Indianapolis, IN 46208.

Dr. Blenker is with the Good Samaritan Hospital in Vincennes, and Dr. Trippi is with Methodist Hospital of Indiana in Indianapolis.

The authors would like to acknowledge Stephen J. Jay, M.D., for his review of this report.

References

1. Marshall WG Jr, Miller CM, Kouchoukos NT: The coronary-subclavian steal syndrome: Report of a case and recommendations for prevention and management. *Ann Thorac Surg*, 46:93-96, 1988.

2. Martin JL, Rock P: Coronary-subclavian steal syndrome: Anesthetic implications and management in the perioperative period. *Anesthesiology*, 68: 933-936, 1988.

3. Melvor ME, Williams GM, Brinker J: Subclavian-coronary steal through a LIMA-to-LAD bypass graft. *Cathet Cardiovasc Diagn*, 14:100-104, 1988.

4. Valentine RJ, Fry RE, Wheelan KR, Fisher DF, Cladgett GP: Coronary-subclavian steal from reversed flow in an internal mammary artery used for coronary bypass. *Am J Cardiol*, 59:719-720, 1987.

5. Niemiera ML, Haft JL, Goldstein JE, Hobson RW: Retrograde internal mammary artery and resistant angina pectoris: Clues to the coronary-subclavian steal syndrome. *Cathet Cardiovasc Diagn*, 12:93-95, 1986.

6. Tarazi RY, O'Hara PJ, Loop FD: Symptomatic coronary-subclavian steal corrected by carotid-subclavian bypass. *J Vasc Surg*, 3:669-672, 1986.

7. Pelias AJ, DelRossi AJ, Tacy L, Wolpowitz A: A case of postoperative internal mammary steal. *J Thorac Cardiovasc Surg*, 90:794-795, 1986.

8. Bashour TT, Crew J, Kabbani SS, Ellertson D, Hanna ES, Cheng TO: Symptomatic coronary and cerebral steal after internal mammary-coronary bypass. *Am Heart J*, 108:177-178, 1984.

9. Tyras DH, Barner HB: Coronary-subclavian steal. *Arch Surg*, 112:1125-1127, 1977.

10. Brown AH: Coronary steal by internal mammary graft with subclavian stenosis. *J Thorac Cardiovasc Surg*, 73:690-693, 1977.



To Plan The Most Successful Conference Possible, You Really Should Check All Your Options.

The University Place Conference Center & Hotel offers all the options you should expect to make your conference a success. And, probably a few things you'd never expect. So, if you'd like a free information packet on the features listed, call **800-627-2700**. Because once you've checked us out, you won't even consider any other location as an option.



University Place

Conference Center & Hotel

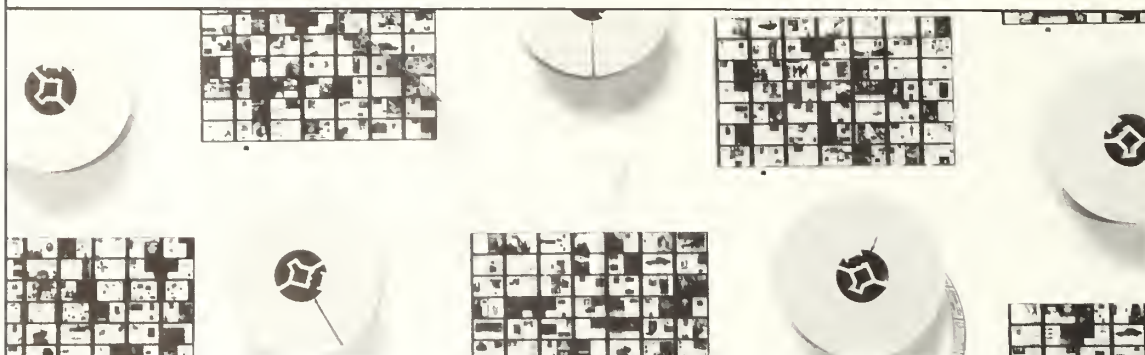
On the Campus of Indiana University • Purdue University
I N D I A N A P O L I S

800-627-2700

(In Indiana 317-274-3196)

Features	<i>University Place</i>
278-room AAA 4-Diamond hotel	✓
Resources of two major universities	✓
338-seat auditorium with sloped seating	✓
Unmatched A/V capabilities	✓
Award-winning restaurants	✓
385-car underground garage	✓
Full-time A/V staff	✓
Turnkey Conference Planning Service	✓
Skywalk to Olympic-class sports facilities	✓
Thirty soundproof meeting rooms	✓
Two tiered meeting rooms	✓
Videoconferencing	✓
Computerized audience response system	✓
Continuous refreshment service	✓

This publication is available in microform.



UMI reproduces this publication in microform: microfiche and 16 or 35mm microfilm. For information about this publication or any of the more than 16,000 periodicals and 7,000 newspapers we offer, complete and mail this coupon to UMI, 300 North Zeeb Road, Ann Arbor, MI 48106 USA. Or call us toll-free for an immediate response: 800-521-0600. From Alaska and Michigan call collect 313-761-4700. From Canada call toll-free 800-343-5299.

U·M·I

A Bell & Howell Company
300 North Zeeb Road, Ann Arbor, MI 48106 USA
800-521-0600 toll-free
313-761-4700 collect from Alaska and Michigan
800-343-5299 toll-free from Canada

Please send me information about the titles I've listed below:

Name _____

Title _____

Company/Institution _____

Address _____

City/State/Zip _____

Phone (_____) _____

Auto Buyers Network

The #1 priority at Auto Buyers Network is to provide you with an easy, timely, and affordable way to purchase your next new or used car, truck or van. Tell us the make and model vehicle that you prefer and **we** do the legwork. No more disputing with salesmen, wondering and worrying if you're getting a "good deal." We can even arrange leasing or financing utilizing the best rates available from several participating lenders.

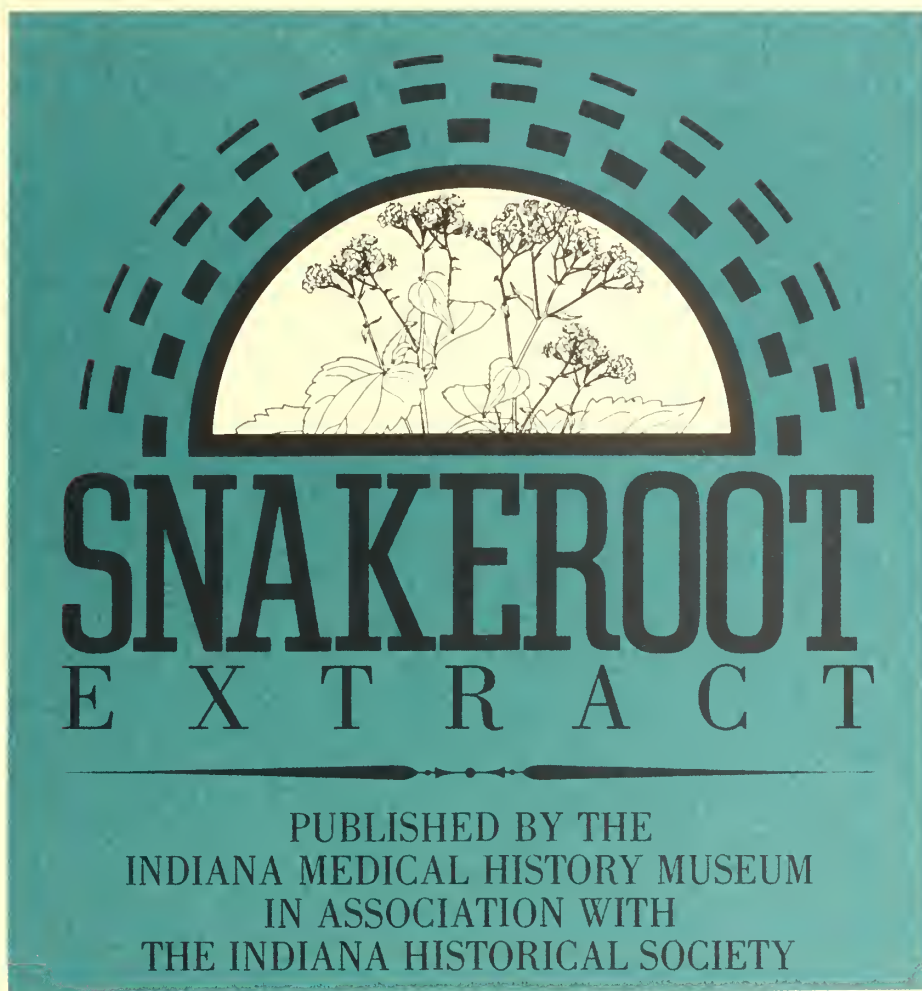
▲ Personalized Service Statewide ▲

Auto Buyers Network

Bill Prewitt, ISMA Consultant

40 West 40th Street, Indianapolis, IN 46208

317/ 921-1537 or 800/736-0172



MUSEUM TO EXPAND VISITING HOURS

The Indiana Medical History Museum this March will expand its open hours to accommodate the increasing number of tourists visiting the historic structure.

Beginning March 15, tourists may visit the museum from 10 a.m. to 4 p.m., Wednesdays through Saturdays. Previously, the museum was open from 1 p.m. to 4 p.m., Wednesdays and Fridays, and at other times by appointment.

More than 1,200 visitors toured the Indiana Medical History Museum during 1991. Those visitors included not only physicians and other health-care professionals but also families and school children interested in the diverse history of medicine.

The number of visitors to the museum has increased dramatically during the past two years. More than 900 tourists and more than 500 tourists visited the museum in 1990 and in 1989, respectively.

Visitors may access the museum, located on the grounds of Central State Hospital, from the hospital's entrance on Warman Street. On Fridays and Saturdays, tourists also may access the museum from an additional entrance at 3045 West Vermont Street.

Admission is \$2 for adults, \$1 for students 18 years old and under, and free for children under six years old.

EXHIBIT TO EXPLORE HISTORY OF PHARMACY

A new exhibit scheduled to open March 22 at the Indiana Medical History Museum will explore the diverse factors that molded the pharmacy profession in America.

During the 1700s, physicians, apothecaries, wholesale druggists and merchants all compounded and dispensed the medications required by the continually expanding population. Often, the businesses established by these professions offered some services provided by the other trades as well.

For example, during this period, the physicians themselves determined whether they preferred to act as physicians, surgeons or apothecaries — branches of medical care in which they received training during their apprenticeships. A publication issued by the New Jersey Medical Society in 1766 noted that, "[T]he office equipment of the doctor makes it clear that he, or his apprentice, was a compounder of medicines [as well]."

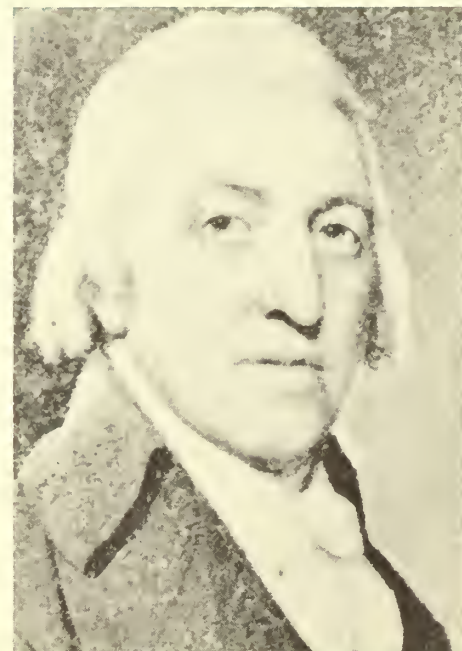
Apothecaries, by contrast, primarily received specialized training in procuring, compounding and dispensing drugs. How-

ever, many apothecaries also engaged in limited practices of medicine.

Both physicians and apothecaries operated shops from which they not only dispensed medications but also sold building materials, dyestuffs and other commodities needed by an increasing number of colonists. Similarly, wholesale druggists and merchants discovered profitability in the production and distribution of drugs, respectively.

The earliest division between the roles of physician and of apothecary occurred at the Pennsylvania Hospital in Philadelphia. In 1754, Benjamin Franklin, who helped found the institution, noted the hospital's need to appoint "an apothecary to attend and make up the medicines daily, according to prescriptions."

This need for specialists to procure, compound and dispense drugs appropriately became re-inforced during the Revolutionary War. Appointed apothecary-general by the Continental Congress, Andrew Craigie in 1778 established a dispensing center for



"I would propose that an apothecary attend each [hospital] with a complete chest of medicines; [and] that the surgeon and physician general of the army be attended by an apothecary with a good chest," wrote Andrew Craigie in 1778. Appointed apothecary-general by the Continental Congress, Craigie helped to demonstrate the need for specialists to procure, compound and dispense drugs appropriately.

(See "Exhibit" on Page 3)

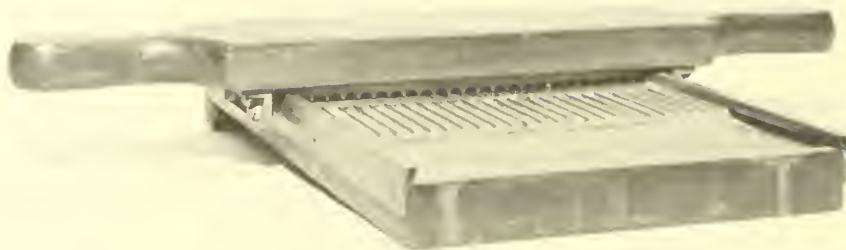
PHARMACISTS USED PILL-TILES, MACHINES

The compounding and dispensing of pills, lozenges, ointments and other medications by the late 1800s became the domain primarily of the pharmacist, although economic necessity prompted some frontier physicians to continue to incorporate pharmacy into their medical practices.

Using a mortar and pestle or a mechanical pill-mixer, the pharmacist began the production process by creating the appropriate pill-mass. This paste consisted of the active ingredients and an excipient, an adhesive or absorbent substance or mixture that not only provided proper consistence but also ensured the pill-mass would retain the desired shape.

Having properly mixed the pill-mass, the pharmacist transferred the mixture to either a pill-tile or a pill-machine, on which the pharmacist rolled the pill-mass into a pill-cylinder about the thickness of a pencil. Although steel spatulas existed by the late 1800s, the pharmacist typically preferred a wooden roller since its width sufficiently covered the entire pill-mass during rolling, and therefore, enabled the pharmacist to eliminate any irregularities in the pill-cylinder's thickness.

The pill-tile enabled pharmacists to produce only a small number of pills at one time. Typically made of porcelain, this



The pill-machine used by pharmacists consisted of two hardwood pieces — a rolling-board encased in metal to prevent warping and a roller which travelled along the length of that metal casing. To facilitate its motion, the roller often contained two small, metal wheels on each of its sides which enabled the roller to travel uniformly along the metal casing of the rolling-board.

device contained a graduated scale by which the pharmacist could determine where to cut the pill-cylinder in order to create the desired number of pieces.

By contrast, the pill-machine enabled the pharmacist to divide and cut large quantities of pills in one session. The device consisted of two hardwood pieces — a rolling-board encased in metal to prevent warping and a roller which travelled along the length of that metal casing.

The top of the rolling-board contained a brass plate with hemispherical grooves that corresponded exactly to a matching plate underneath the roller. Using handles on the

roller, the pharmacist, consequently, would divide the pill-cylinder by applying pressure downward as he moved the roller backwards along the rolling-board. Once completed, the pharmacist then divided the contents in each groove into the desired number of pills.

After completing the cutting on the pill-tile or with the pill-machine, the pharmacist either individually rolled the pills between his fingers or used a pill-finisher to impart the desired spherical shape. Once dried, the pills were coated to mask their taste and then polished to complete the process.

Snakeroot Extract derives its name from the white snakeroot plant, which significantly impacted medical history in Indiana. Many early Hoosiers experienced milk sickness, a mysterious disease the cause of which remained unknown until the 1920s. At that time, physicians traced the disease to the white snakeroot, or rather, to the consumption of milk from cows that had grazed on the plant. The white snakeroot contains the poison tremetol.

The Indiana Medical History Museum publishes **Snakeroot Extract** in association with the Indiana Historical Society. Thus, the members of the museum and the members of the Indiana Historical Society (who request this publication) receive this newsletter. Individuals should direct inquiries about membership in the Indiana Historical Society to: Indiana Historical Society, 315 West Ohio Street, Indianapolis, IN 46202-3209, (317) 232-1882.

Interested individuals should submit items for publication and direct any inquiries about museum membership to: Oren S. Cooley, Indiana Medical History Museum, 3000 West Washington Street, Indianapolis, IN 46222-4055, (317) 635-7329.

MUSEUM ACCEPTS NURSING UNIFORM

The Indiana Medical History Museum recently accepted into its collection the uniform worn by a United States Army Red Cross Reserve Nurse during World War I.

Patricia and Orville Selig of Madison, Ind., gave the museum the uniform along with several books and other publications. The uniform originally belonged to Ms. Selig's mother, Kathryn Tuttle Hill.

A 1917 graduate of the St. Vincent Hospital School of Nursing in Indianapolis, Ms. Hill became a Red Cross reserve nurse for the U.S. Army after completing her studies. "The war had created such a demand for nurses that mother entered the service immediately," explained Ms. Selig.

More than 20,000 nurses were assigned to military service after 1917, when the American Red Cross Nursing Service became the nursing reserve for the U.S. Army and Navy.



The uniform of the U.S. Army Red Cross Nursing Service consisted of a woolen jacket, skirt and hat and a silk blouse.

EXHIBIT

(Continued from Page 1)

medications and organized apothecaries to supply not only the medicinal requirements of army hospitals but also the medicine chests maintained by the various regiments.

During the 1700s and early 1800s, the lack of enforceable standards in the health field encouraged the unbridled promotion of drugs and patent medicines — those cure-all nostrums the contents of which manufacturers kept secret because of the inclusion of dangerous ingredients such as mercury, arsenic or large amounts of alcohol. However, early attempts by physicians to regulate the production and dispensing of medications proved futile.

As a result of this pressure from the medical profession, apothecaries began to seek standards by which to regulate their affairs according to their own ideas. In 1821, apothecaries and druggists formed the Philadelphia College of Apothecaries after the University of Pennsylvania announced its intention to grant degrees to apothecaries who passed the university's proposed examinations.

In their attempt to develop their profession, apothecaries began to adopt the terminology and the practices of their French and German counterparts, who conducted their activities on the basis of professional ideas and scientific knowledge. As a result, the Philadelphia College of Apothecaries changed its name in 1822 to the Philadelphia College of Pharmacy in order to resemble the Collège de Pharmacie, an association of Parisian pharmacists that included members of high scientific attainment.

This foreign influence increased after 1825, when Elias Durand, the former phar-



This illustration, which originally appeared in a book of vocational guidance, depicts the interior of an apothecary's shop in the early 1800s. Although they received specialized training in procuring, dispensing and compounding drugs, some apothecaries also engaged in limited practices of medicine.

macist of the Grand Army of Napoleon I, immigrated to Philadelphia and established a business. Pharmacist William Proctor, Jr., noted his contemporary's importance when he wrote, "His [Durand's] store became an important center of pharmaceutical information, which directly and indirectly had much to do with the introduction of scientific pharmacy into Philadelphia, and through this college, its Journal and graduates into the United States."

The German immigration during the late 1840s and early 1850s included many well-educated pharmacists who also possessed excellent scientific training. Inclined towards professional ideas, these pharmacists also encouraged the profession's growth in the middle and late 1800s by nurturing the formation of various associations.

Until the 1850s, however, pharmacists did not possess the nationwide organization needed to encourage professional development among pharmacists and to foster the founding of state organizations. In 1852, William Proctor, Jr., witnessed the realization of his dream to organize a national association when representatives from the various colleges of pharmacy set up the American Pharmaceutical Association.

Despite these advances towards developing strictly professional pharmacies, economic conditions during the 1800s still prompted pharmacists to operate businesses that not only dispensed medications but also served as general stores. After the Civil War, the rise of the textile and building industries prompted many pharmacists to seek other supplemental ventures, such as the business generated by the soda fountain, to replace the vanishing trade in dyestuffs and building materials.

By the turn of the century, pharmaceutical companies began to replace the pharmacist as the primary manufacturers of pills and other medications. In *A Treatise on Pharmacy for Students and Pharmacists* (1895), Charles Caspari, Jr., Ph.G., documented this trend when he wrote, "[T]he opportunities for a practical acquaintance with the details of [pharmacy] work are growing less day by day, owing to the untiring efforts of manufacturers to induce physicians to specify factory-made pills on their prescriptions."

[Sources: [Eduard] Kremers' and [George] Urdang's *History of Pharmacy* (1976) revised by Glenn Son-nedecker, Ph.D., and *A Treatise on Pharmacy for Students and Pharmacists* (1895) by Charles Caspari, Jr., Ph.G.]



Intense competition among physicians, apothecaries, wholesale druggists and merchants to provide medications prompted many pharmacists to supplement their primary trade with various business ventures, ranging from building materials to confectioneries. This pharmacy, owned by Frank and Robert Bergmann, reflects the typical appearance of many establishments during the late 1800s.

MUSEUM SELECTS ARCHITECTURAL FIRM

The Indiana Medical History Museum recently selected Sites and Structures, Inc., as the architectural firm for the \$10,000 matching grant slated to fund several improvements to the museum's historic structure.

The Indianapolis-based firm, established in 1988, specializes in providing technical assistance on historic preservation and rehabilitation projects. The firm's previous projects include the rehabilitation of the Tarzian residence in the Lockerbie Square Historic District in Indianapolis and the replication of the North Overlook at Brown County State Park.

The matching grant was awarded last year by the Indiana Department of Natural Resources' Division of Historic Preservation and Archaeology. The United States Department of the Interior provides the monies for this grant program through the Historic Preservation Fund.

The museum will use the matching grant to install a new flat roof on the rear portion of the historic structure. Besides installing a new roof, this project will include repairing the building's three skylights and replacing the gutters in several locations.

INTRODUCTION OF LITHOGRAPHY ADVANCES MEDICAL ILLUSTRATION

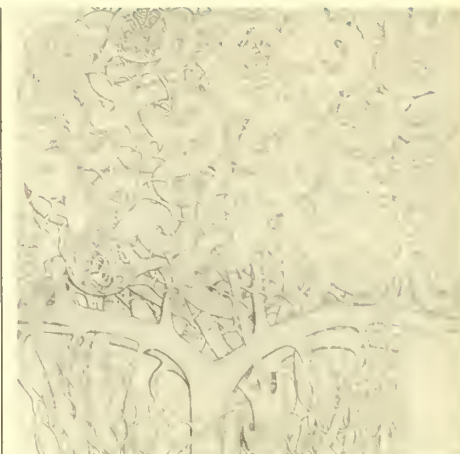
"Art has become more and more indispensable to us as an aid both to record and to explication. The diagram, the more highly finished drawing, . . . serve as a new language that speaks with strength and clearness where written or spoken words would convey their meaning slowly and imperfectly."

— William Anderson (1886)

Medical illustration greatly advanced during the 1800s after the introduction of lithography — a process that enabled printers to easily reproduce drawings that contained fine detail and color.

Alois Senefelder, a German printer, invented lithography while conducting research into printing techniques during the 1790s. At that time, printing processes required that printers either carve in relief or incise the printing plate in order to reproduce the desired illustration.

However, Senefelder discovered a technique in which the printer could trace the image directly onto a flat piece of stone by using a greasy chalk pencil. When soaked with water, the stone's surface completely absorbed the water except for the greased sections.



Lithography advanced medical illustration by enabling printers to easily reproduce drawings that contained fine detail and color. This lithograph, which depicts a cross section of the kidney, was produced by Indianapolis lithographer William B. Burford around the turn of the century. (From the collection of the Indiana Medical History Museum)

The opposite occurred when the printer then applied the greasy printing ink, which adhered to the greased sections that had repelled the water. Once prepared in this manner, the stone could transfer the inked image to paper or other material during the printing process.



Indiana Medical History Museum
3000 West Washington Street
Indianapolis, IN 46222-4055
(317) 635-7329

PLANT PHYSICIAN

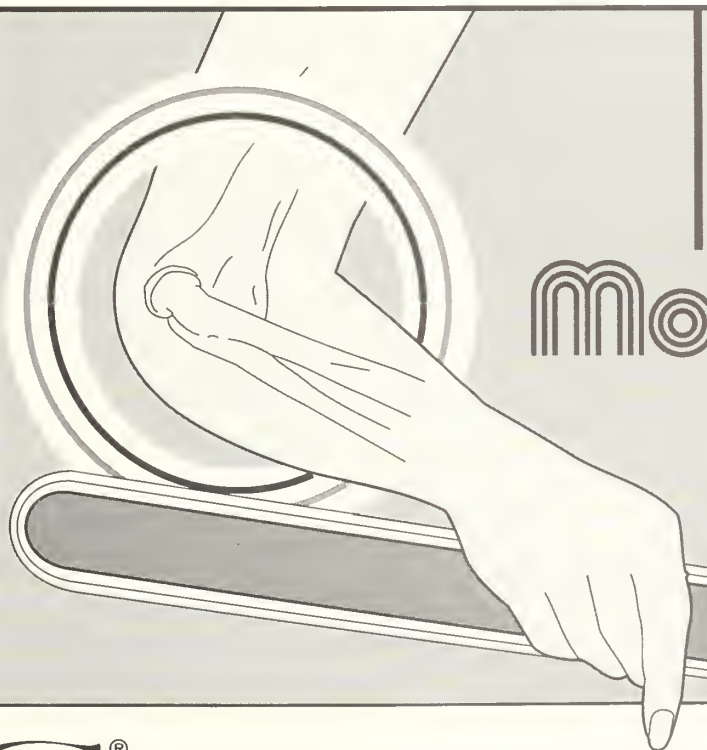
CONNERSVILLE, IN.

Automotive manufacturer is seeking a full-time plant physician for its Connersville, Indiana facility (located 60 miles southeast of downtown Indianapolis). This position is an integral part of the management team. Responsibilities include the supervision of the nursing staff, providing health services and evaluation for 3,000 + employees, development and implementation of pro-active employee health programs, and involvement in employee safety programs. Board certification in internal medicine or family practice with industrial experience, or Board qualified or Board certification in occupational health preferred. Experience in an unionized industrial setting a plus.

Competitive salary, paid malpractice, excellent benefits including 401-K. Call or send resume to: **Mike Schulhoff, Ford Electronics and Refrigeration Corporation, State Road #1, Connersville, IN 47331; (317) 827-7016.**



Equal Opportunity Employer



SAFE
EFFECTIVE
CONVENIENT
ECONOMICAL

Mono-Gesic[®] Tablets
(750mg Salsalate)

A well tolerated
Salicylate Therapy



CENTRAL PHARMACEUTICALS, INC.

SEYMOUR, INDIANA 47274 USA

Quality Pharmaceuticals Since 1904

■ annual reports

Editor's note: The following annual reports were inadvertently omitted from the January issue of INDIANA MEDICINE.

COMMISSION ON MEDICAL EDUCATION

James E. Carter, M.D., chairman

The Commission on Medical Education and its Subcommittee on Accreditation each met Nov. 18, 1990, and April 28, 1991. Stephen Jay, M.D., is chairman of the Subcommittee on Accreditation, and Donald Dian, M.D., is vice-chairman of the Subcommittee on Accreditation. Glenn Bingle, M.D., is vice-chairman of the Commission on Medical Education and Chairman of the Subcommittee on Physician Remedial Education. During this year, nine institutions and 12 organizations were accredited.

The Subcommittee on Accreditation submitted an interim report to the Committee for Review and Recognition of the Accreditation Commission of Continuing Medical Education. The Subcommittee and the Commission on Medical Education addressed the issues raised in a progress report that was accepted by the Committee for Review and Recognition on June 19, 1990.

Developing an accreditation process that is similar for both organizations and institutions was an important issue that the Subcommittee and the Commission on Medical Education addressed this year. This issue required considerable time and effort on the part of the Commission Steering Committee, Commission and Subcommittee members and staff of the ISMA. As a result of this work, a new accreditation guidebook and application have

been printed.

In a report given by Dr. Bingle to the Association of Indiana Directors of Medical Education, it was noted that there were only four states (California, Michigan, Massachusetts and Wisconsin) with a greater number of accredited CME sponsors than Indiana. The ISMA now accredits 60 CME sponsors.

The Subcommittee on Physician Remedial Education met Feb. 15 with members of Sentinel. There was a discussion of current problems and concerns. It was agreed that the current system is educationally not sound. It was agreed that Sentinel would not make further referrals to the subcommittee for remedial education at this time. The subcommittee will investigate the possibility of developing a centralized, personalized, physician educational program. There is a need for better determination of the educational needs, better feedback and evaluation of participants and a better financial structure.

Dr. Bingle and Dorothy Martens attended the ACCME Conference in Chicago Sept. 22-23, 1990. Dr. Carter attended the ACCME meeting in Chicago March 15-16, 1991. Dr. Jay is a member of the ACCME. These meetings provided an important dialogue between Indiana and national CME educators.

During commission meetings, the educational programs at the Indiana University School of Medicine were discussed. In June 1991, a third-year curricular program was started with several significant changes, including a family medicine clerkship. Students spend one month with a family medicine preceptor in locations throughout the state. Additional time was added to the

clerkship in psychiatry. Much of this additional time will be spent in treatment centers for substance abuse. A new Department of Psychiatry was formed at the I.U. School of Medicine.

I wish to express my appreciation to members of the subcommittee and commission for their input and work during a very busy and important year. I also would like to acknowledge and thank the ISMA administrative staff for the support received.

COMMISSION ON PHYSICIAN ASSISTANCE

Robert R. Nelson, M.D., chairman

This has been a busy yet exciting year for the Commission on Physician Assistance (COPA). Candace Backer joined the staff as the full-time COPA coordinator in July 1990. She is a certified social worker and a certified addictions counselor. She came to us with more than 10 years' experience. During this year, she and Kete Cockrell, M.D., medical consultant to the Physician Assistance Program (PAP), have accomplished a variety of goals.

To date, they have:

1. maintained a primary focus on educating the ISMA membership on the scope of the problem of physician impairment, and on increasing members' awareness of services available to them;
2. attended and spoken at more than 33 county medical society or hospital medical staff meetings;
3. worked closely with several county- and hospital-based physician assistance committees, with a goal of centralizing services and contracts. This will enable our state to offer consistent, high-

■ annual reports

quality services to physicians and families who suffer from an impairment;

4. developed a clear and concise policy and procedure manual for the operation of the program;

5. spoken at the annual board meeting of the ISMA Auxiliary, as well as met with several county auxiliary groups;

6. met regularly with the COPA Executive Committee and quarterly with the full commission;

7. offered a seminar on addictions to ISMA members throughout five regions of the state; these were at no cost, and CME credit was offered;

8. assisted several physicians in re-obtaining their DEA numbers from the Medical Licensing Board.

Recently, we have received confirmation from the Indiana University School of Medicine that its board has accepted our proposal to implement a Physician Assistance Program for their

medical staff and faculty. We also are in the early stages of developing a fee-for-service contract to offer our program to other hospitals to aid in generating program revenue.

Finally, we have received and investigated information on more than 38 new cases this year. We presently are monitoring 40 physicians in the state, and 30 of these physicians are ISMA members. Family practitioners are the number one specialty represented, with emergency room physicians and anesthesiologists closely following. Problems with alcohol and/or drugs comprise more than 85% of our cases, with psychiatric or other problems constituting the remainder.

FIFTH DISTRICT

Fred Haggerty, M.D., trustee

The Fifth District held its annual meeting May 29. A financial advisor from a brokerage firm spoke

on investing.

Dr. Roland Kohr was elected alternate trustee for three years. Numerous door prizes were distributed to many district members.

This year, we held quarterly meetings with mixed success. Dr. Peggy Sankey-Swaim resigned as district secretary, and Dr. Farid was appointed as the new secretary/treasurer.

Our next quarterly meeting, Nov. 21, will be held at the Farrington House in Terre Haute and will focus on legislative issues. Several political representatives will be invited.

The next annual meeting will be May 28 in Greencastle. Dr. Rudolph is organizing that program.

Parke, Vermillion and Vigo counties have united as one local society. They will meet monthly, except during the summer. Putnam and Clay counties have started meeting together monthly. □

■ auxiliary report

Pat Walker **Vigo County Auxiliary President**

The Vigo County Medical Auxiliary will host this year's State Medical Auxiliary Convention April 22 through 24 at the Terre Haute Holiday Inn. The convention will feature Father George Clements, a national leader in the fight against drugs, and Sherry Strebel, national AMA-A president, as speakers.

In his war against drugs, Father Clements forced drug dealers

out of his parish in inner-city Chicago. His success was the subject of a television movie. Sherry Strebel of Oklahoma will address "Violence in the Family," the theme of her ongoing campaign to help curb domestic violence.

This year's convention theme is "Spice Up Your Life With Auxiliary." A collection of spice recipes will be distributed during the convention.

The House of Delegates will meet Thursday and Friday mornings. Trudy Urgena, ISMA-A president-elect, will be installed as

the 49th auxiliary president.

All auxiliaries are invited to attend the convention. Registration forms will be mailed in the March issue of *The Pulse*. If you have questions, call Rosanna Iler at the ISMA, (317) 261-2060 or 1-800-257-ISMA.

I would like to thank ISMA Auxiliary President Kay Enderle and Convention Co-chairmen Pam Pangan and Muriel Kunkler, who are planning the convention with Vigo County auxiliaries. Their dedication and leadership are greatly appreciated. □

1991 Indiana State Medical Association membership report as of Dec. 31, 1991

	Active	1st year	Resident	Dues Exempt	Total
Adams	10	0	0	2	12
Bartholomew/Brown	80	1	1	19	101
Benton	1	0	0	1	2
Boone	16	1	1	8	26
Carroll	8	2	0	1	11
Cass	30	0	1	12	43
Clark	86	1	0	10	97
Clay	8	0	0	5	13
Clinton	15	0	0	4	19
Daviess/Martin	12	1	0	10	23
Dearborn/Ohio	30	0	0	3	33
Decatur	9	0	0	4	13
DeKalb	14	1	0	4	19
Delaware/Blackford	150	3	4	26	183
Dubois	37	1	0	5	43
Elkhart	130	3	0	34	167
Fayette/Franklin	23	0	0	5	28
Floyd	70	2	0	15	87
Fort Wayne/Allen	398	11	33	94	536
Fountain/Warren	8	0	0	2	10
Fulton	6	0	0	0	6
Gibson	9	0	0	4	13
Grant	70	0	1	25	96
Greene	10	0	0	5	15
Hamilton	47	1	2	3	53
Hancock	32	1	1	4	38
Harrison/Crawford	12	1	0	1	14
Hendricks	39	1	0	6	46
Henry	24	0	0	9	33
Howard	90	4	1	21	116
Huntington	17	0	0	6	23
Indpls./Marion	1,510	48	48	283	1,889
Jackson	19	2	0	6	27
Jennings	4	0	0	1	5
Jasper/Newton	14	0	0	4	18
Jay	10	0	0	6	16
Jefferson/Switzerland	29	0	0	8	37
Johnson	45	0	2	5	52
Knox	50	2	0	12	64
Kosciusko	27	1	0	2	30
LaGrange	12	0	0	3	15

	Active	1st year	Resident	Dues Exempt	Total
Lake	578	2	1	111	692
LaPorte	101	1	0	22	124
Lawrence	40	0	0	7	47
Madison	121	4	0	32	157
Marshall	19	0	0	6	25
Miami	12	1	0	4	17
Montgomery	30	1	0	8	39
Morgan	26	0	0	4	30
Noble	16	0	0	2	18
Orange	5	0	0	1	6
Owen/Monroe	146	6	0	18	170
Parke/Vermillion	7	0	0	5	12
Perry	4	1	0	1	6
Pike	1	0	0	0	1
Porter	123	1	0	11	135
Posey	2	0	0	1	3
Pulaski	5	1	0	1	7
Putnam	11	0	0	4	15
Randolph	6	0	0	3	9
Ripley	12	0	0	0	12
St. Joseph	275	6	7	81	369
Scott	4	0	0	2	6
Shelby/Rush	27	0	0	6	33
Spencer	0	0	0	0	0
Starke	8	0	0	2	10
Steuben	10	0	0	7	17
Sullivan	6	0	0	4	10
Tippecanoe	169	5	2	40	216
Tipton	6	0	0	3	9
Vanderburgh	347	10	3	82	442
Vigo	131	1	1	26	159
Wabash	22	0	1	7	30
Warrick	16	0	0	0	16
Washington	6	0	0	1	7
Wayne/Union	81	3	0	22	106
Wells	44	1	0	14	59
White	5	1	0	4	10
Whitley	7	0	0	3	10
RMS	0	0	132	0	132
1991 totals	5,640	133	242	1,223	7,238
1990 totals	5,614	168	305	1,117	7,204

Membership information

	Active members	Chg from prior yr. active members:	Chg from prior yr. dues exempt mbrs:	Total:
1991	6,015	- 72	1,223 (+106)	7,238
1990	6,087	+ 68	1,117 (+29)	7,204
1989	6,019	- 75	1,088 (+76)	7,107
1988	6,094	+ 125	1,012 (-2)	7,106
1987	5,969	+ 298	1,014 (+1)	6,983

■ about the artist

Art has become a way for Ray Gencius to explain how he feels about living with AIDS.

Gencius, whose art appears on this month's cover of *INDIANA MEDICINE*, first began drawing pictures of his experiences with AIDS in late 1989, a couple years after he was diagnosed with the disease. He became interested in expressing himself artistically as a result of weekly art therapy sessions at the Damien Center, an AIDS social service organization in Indianapolis.

Drawing was more self-gratifying than discussion support groups, Gencius said. It also enabled him to "leave something

behind."

The pictures are his attempt to portray the everyday experiences of a person with AIDS. His drawings of health care professionals often reflect his gratitude to them for their care. The pictures also represent his interpretation of the "inner turmoil" about factors that affect everyone, but often are intensified for people with AIDS. He cites family relationships, economics and religion as examples. For example, he says he went from enjoying a middle-class professional lifestyle to living on a disability income.

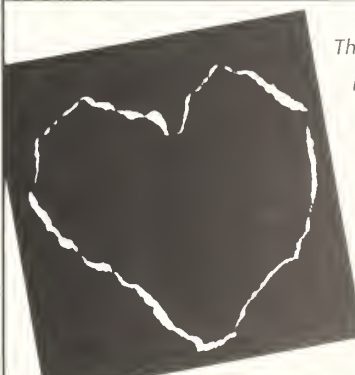
Reactions to his drawings, which are bold and brightly colored, are usually very positive,

often to his surprise, Gencius said. People have offered to buy them, but he has been reluctant to put a price on them. He has given some away, however.

The University of Indianapolis featured his works during an exhibit in February.

Gencius is the public relations director for Indiana Cares, the oldest and largest AIDS support organization in the Midwest. The group plans fund-raisers for AIDS support and educational efforts.

Gencius plans to produce more drawings. "I still have a lot of ideas floating in my head," he said. □




*The Midwest Cardiovascular Research Foundation
presents the 7th Annual Spring Conference at
Amelia Island Plantation, Florida*

Acute Myocardial Infarction

The Era of Reperfusion

**Mark your
calendars
now!**

April 30-May 3, 1992



Contact Person: Martha Hopewell
219-482-4865

PO Box 11788
Fort Wayne, IN 46860

CARDIOLOGY – DIAGNOSTIC & INTERVENTIONAL



NASSER, SMITH AND PINKERTON CARDIOLOGY, INC.

William K. Nasser, M.D.
Michael L. Smith, M.D.
Cass A. Pinkerton, M.D.
James W. VanTassel, M.D.
Dennis K. Dickos, M.D.
John D. Slack, M.D.
Charles M. Orr, M.D.
Jane Howard, M.D.
James H. Adlam, M.D.
V. Michael Bournique, M.D.
Frank J. Green, M.D.
Nancy A. Branyas, M.D.
Charles P. Taliercio, M.D.
Bruce F. Waller, M.D.
Thomas F. Peters, M.D.
Azim Saqib, M.D.
Lawrence E. Gering, M.D.

providing

Cardiology & Cardiac Catheterization
Transesophageal Echocardiography
Doppler & Echocardiography
Exercise Stress Testing
Coronary Angioplasty
Nuclear Cardiology
Pacemaker Surveillance
Holter Monitoring
Percutaneous Valvuloplasty
Electrophysiology Testing
Coronary Atherectomy
Myocardial Biopsy
Automatic Implantable
Cardioverter Defibrillator
Signal Averaged Electrocardiography

Suite 400
St. Vincent Professional Building
8402 Harcourt Road
Indianapolis, Indiana 46260

Office: 317-871-6666
1-800-732-1482 (Indiana)
1-800-CHD-PTCA (Indiana)
FAX: 317- 871-6019

THE HEART CENTER OF INDIANA

CARDIOLOGY

FORT WAYNE CARDIOLOGY

Basil C. Genetos, M.D.
Robert W. Godley, M.D.
Michael J. Mirro, M.D.
Kevin J. Kelly, M.D.
Fred Doloresco, M.D.
John F. Phillips, M.D.
Patrick J. Daley, M.D.
William W. Wilson, M.D.
James J. Heger, M.D.
Raymond E. Dusman, M.D.
Charles F. Presti, M.D.
Stephen E. Brown, M.D.
David D. Whang, M.D.

Practice Limited to Cardiology
(Physician's Referral Only)

Locations nearby:

1912 Carew Street
Fort Wayne, Indiana 46805
(219) 482-4865 (800) 637-6505 (IN)
(800) 334-4371 (MI & OH)

Lutheran Medical Park
7900 W. Jefferson Blvd.
Suite 202
Fort Wayne, Indiana 46804
(219) 432-5613

Caring for people is the first priority at Fort Wayne Cardiology. Since 1978, our team approach has served referring physicians and their patients with the latest in heart care treatment and technologies.

Fort Wayne Cardiology is a trusted and caring group of people, featuring 13 board certified/board eligible cardiologists, as well as a special staff of nurses, technologists and administrative assistants. Patients are able to receive comprehensive cardiac services which include: cardiac catheterization, coronary angioplasty and atherectomy, electrophysiology, valvuloplasty, nuclear cardiology, doppler and echo cardiography, exercise stress testing, holter monitoring, ECG event monitoring, permanent pacemaker implantation and surveillance, non-invasive peripheral vascular evaluation, peripheral angioplasty and atherectomy, myocardial biopsy, transesophageal echo, AICD insertion and surveillance, signal average EKG, tilt table and rehab therapy.

University trained, certified cardiologists; the best in diagnostic equipment; clinical research and specialization within the specialty, makes Fort Wayne Cardiology an excellent center for heart care.

Satellite Clinics:

Angola	Kendallville	Defiance, OH
Auburn	LaGrange	Hicksville, OH
Columbia City	Wabash	
Huntington	Warsaw	

CARDIOLOGY

A new era in heart care has begun...

Now open



Robert E. Swint, Sr., M.D.

Mark A. Jones, M.D.

David A. Kaminskas, M.D.

Gary A. Hambel, M.D.

Mary H. Heintz, M.D.

Ravi N. Bathina, M.D.

Gregory C. Tomlinson, M.D.

Brian T. Lew, M.D.

Peter C. Hanley, M.D.

Christopher Zee-Cheng, M.D.

Steven W. Orlow, M.D.

David A. Belvedere, M.D.

Mark S. Hazen, M.D.

7836 W. Jefferson Blvd.

Fort Wayne, IN 46804

(219) 432-2297

800 Broadway, Suite 204

Fort Wayne, IN 46802

(219) 422-2558

3217 Lake Ave.

Fort Wayne, IN 46805

(219) 422-2297

2510 Dupont Rd.

Fort Wayne, IN 46825

(219) 489-8280

1-800-777-2297

CARDIOLOGY

Indiana Heart Physicians, Inc.

a member of the
Indianapolis Regional Heart Center
at St. Francis

Indianapolis/Beech Grove Medical Center
112 North 17th Avenue, Suite 300

Office	317-783-8800
Appointment Scheduling	317-781-3615
Cardiac Testing Center	317-781-3636
Toll Free (Nationwide)	800-992-2081

Consulting Offices at:

Greenwood
Shelbyville
Martinsville

Indiana Heart Physicians at Columbus
3154 North National Road, Suite C

Office	812-379-2020
Toll Free (Indiana)	800-331-4765

Physicians

H. O. Hickman, Jr., M.D., FACC
Thomas M. Mueller, M.D., FACC
J. Douglas Graham III, M.D., FACC
Kathleen H. Flohr, M.D., Ph.D., FACC
Jeffrey L. Christie, M.D., FACC
Stephen H. Kliman, M.D., FACC
Thomas C. Passo, M.D., FACC
Emily A. Diltz, M.D., FACC
John E. Batchelder, M.D., FACC
Mark D. Cohen, M.D., FACC
William J. Berg, M.D.
Thomas D. Hughes, D.O.
George E. Revtyak, M.D., FACC

at Columbus

David J. Hamilton, M.D., FACC
Kevin C. Preuss, M.D., FACC

providing

Cardiology and Cardiac
Catheterization
Coronary Angioplasty
Coronary Atherectomy
Electrophysiology
Percutaneous Valvuloplasty
Nuclear Cardiology
Stress Echocardiography
Exercise Stress Testing
Holter Monitoring
ECG Event Monitoring
Permanent Pacemaker Implantation
Pacemaker Surveillance
Color Flow Doppler Echocardiography
Laser Angioplasty
Trans-Telephonic Pacemaker Analysis

Noninvasive Peripheral
Vascular Evaluation
Signal Average EKG
Myocardial Biopsy
Tilt Table Testing

CARDIOLOGY

THE HEART CENTER OF MARION



Prakash N. Joshi, M.D., F.A.C.C.
Diplomat, American Board of
Internal Medicine & Cardiovascular
Diseases

Subodh S. Gupte, M.D., F.A.C.C.
Diplomate, American Board of
Internal Medicine, Cardiovascular
Diseases and Advanced Achievement
in Internal Medicine

providing
Cardiology
Electrocardiogram
Exercise Stress Testing
Doppler &
Stress
Echocardiography
Echocardiography
Holter Monitoring

703 Chapel Pike
Marion, Indiana 45952
Appointments: (317) 664-1201
Business Office: 1-800-345-2035
FAX: (317) 664-2866

Nasser, Smith & Pinkerton Cardiology, Inc.

DOCTORS

These spaces are available.

For rates, write or call
INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

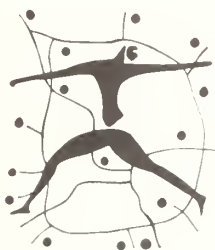
PLASTIC, RECONSTRUCTIVE & HAND SURGERY

One Call, Day or Night!

Our group is always available, 365 days a year, day or night; to see your patients in Indianapolis because there are times when your patient shouldn't have to wait.

**ALSO SEEING PATIENTS
BY APPOINTMENT IN THESE
CENTRAL INDIANA CITIES:**

DOWNTOWN
GREENCASTLE
DANVILLE
CRAWFORDSVILLE
LEBANON
KOKOMO
BEECH GROVE
GREENWOOD
MOORESVILLE
SURGERY CENTER



**SERVING 15 CENTRAL
INDIANA HOSPITALS**

VISA, MASTERCARD ACCEPTED
FINANCING AVAILABLE

ZOLLMAN CENTER FOR PLASTIC & HAND SURGERY

1633 North Capitol Avenue, Indianapolis IN 46202



Member American Society
of Plastic and Reconstructive Surgeons

317-924-4943

1-800-332-3943

FAX: 317-921-3109

Wally Zollman M.D., F.A.C., Twatchai Yamcharern M.D., Richard S. Troiano M.D., Rank O. Dawson, Jr., M.D.

PLASTIC SURGERY

PLASTIC SURGERY



AMERICAN SOCIETY OF
PLASTIC & RECONSTRUCTIVE
SURGEONS, INC.

John G. Pantzer Jr., M.D., F.A.C.S.
Diplomate, American Board
of Plastic Surgery

1801 North Senate Blvd., Suite 735
Indianapolis, Indiana 46202
317-929-5500

MERIDIAN PLASTIC SURGERY CENTER

For information on services
317/575-0110
or **800/352-7849**
106th & Meridian Streets
Indianapolis

An Ambulatory Surgery Center
Exclusively for Cosmetic, Plastic
and Reconstructive Surgery

Board-Certified Physicians

- Stephen W. Perkins, MD, FACS
- William R. Nunery, MD, FACS
- Ronald T. Martin, MD
- A. Michael Sadove, MD, FACS



Facial, Ophthalmic & General
Plastic Surgery • Anesthesiology

Licensed by the Indiana State
Board of Health • Medicare
Certified

RADIOLOGY

SUPERB QUALITY DIAGNOSTIC RADIOLOGY AND RADIATION ONCOLOGY SERVICES ARE ONLY A TELEPHONE CALL AWAY...

Our mission is to provide caring, high quality, state-of-the-art imaging, interventional, and radiation oncological services to our patients, referring clinicians, and institutions. Call us today to discuss your unique requirements or to refer your patients for prompt, courteous, cost effective, and professional service.

INDIANAPOLIS

Methodist Hospital
1701 N. Senate Avenue
Methodist Professional Center
1801 North Senate Avenue
(317) 929-3580

Methodist Hospital Breast Cancer
Screening Program
(317) 929-5000

Eagle Highlands Radiologic Services
6920 Parkdale Place
Suite 111
(317) 291-4411

Lakeview Radiologic Services
9002 North Meridian Street
Suite 110
(317) 844-6944

BROWNSBURG

Brownsburg Radiologic Services
1375 North Green Street
Suite 200
(317) 852-3222



COLUMBUS

(Radiation oncology only)
Bartholomew County Hospital
2400 East Seventeenth Street
(812) 376-5361

CRAWFORDSVILLE

Culver Union Hospital
1710 Lafayette Road
(317) 364-3146

GREENSBURG

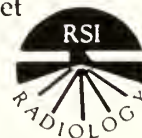
Decatur County Memorial Hospital
720 North Lincoln Street
(812) 663-1156

KOKOMO

(Radiation oncology only)
Howard Community Hospital
3500 South Lafountain Street
(317) 453-8189

TERRE HAUTE

(Radiation oncology only)
Union Hospital
1606 North Seventh Street
(812) 238-7504



RADIOLOGIC SPECIALISTS OF INDIANA, INC.

All Physicians Board Certified.

CLINICAL & ANATOMIC PATHOLOGY

The Medical Laboratory

of Drs. Thornton-Haymond-Costin-Buehl-Bolinger-Warner-McGovern-McClure-Hooker-Winkler
5940 West Raymond Street • Indianapolis, Indiana 46241

CHEMISTRY
MICROBIOLOGY
HEMATOLOGY
TOXICOLOGY
CYTOLOGY
HISTOLOGY
CUSTOMER SERVICE



Courier Service
24 hr. Pathology Consultation
Assignment Accepted: Medicare/Medicaid
BC/BS VIP and PC/USA, Preferred Care, Prucare
18 Convenient Branch Locations

CENTRAL TESTING FACILITY: 5940 W. Raymond St., Indianapolis, IN 46241
Phone: 317/248-2448

"Here Today To Serve You Tomorrow."

DOCTORS

This space is available.

For rates, write or call
INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

PULMONARY DISEASE

RESPIRATORY CONSULTANTS OF INDIANA

DAVID B. COOK, M.D., FCCP
CHRIS C. NAUM, M.D.

MICHAEL R. NIEMEIER, M.D., FCCP
THOMAS Y. SULLIVAN, M.D.
JOHN A. WARDEN, M.D., FCCP

ROBERT W. WELLER, M.D., FCCP
PATRICK E. WRIGHT, M.D., FCCP

Pulmonary Disease

Lung and lung-heart transplantation
Laser Bronchoscopy
Intra-bronchial radiation therapy
Trans-tracheal oxygen therapy
Complete rest and exercise
physiologic testing

Critical Care

Physicians ABIM certified in
critical care 24 hours/day
State-of-the-art eighty bed
intensive care facility

Hyperbaric Medicine

Diagnostic assessment
of local oxygen delivery
Treatment of disorders of
regional O₂ delivery and
utilization

Sleep Disorders

Clinical polysomnographer
Full-service polysomnography
laboratory

1801 N. SENATE BLVD., SUITE 400, INDIANAPOLIS, IN 46202 • OFFICE (317) 929-5820 • FAX (317) 929-3916
6920 PARKDALE PLACE, SUITE 215 • INDIANAPOLIS, IN 46254 • OFFICE (317) 328-6635 • FAX (317) 328-6640
GREENSBURG (812) 653-5533 • LEBANON (317) 873-2103 • RUSHVILLE (317) 932-4111 • TERRE HAUTE (812) 232-0564
AFTER HOURS. ANSWERING SERVICE (317) 926-3466 OR 1-800-772-7788

1-800-321-LUNG • MONDAY - FRIDAY 8:30 A.M. - 4:30 P.M.

ALCOHOLISM TREATMENT

Eugene G. Roach, M.D.
Executive/Medical Director



Anderson Center
of Saint John's

1-800-435-9143 or (317) 646-8383

- Comprehensive Alcohol and Drug Treatment
- Separate Programs for Adolescents and Adults
- Free Assessment and Intervention

DOCTORS

This space is available.

For rates, write or call

INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

INTERNAL MEDICINE

NEPHROLOGY & INTERNAL MEDICINE, INC.

Thomas Wm Alley M.D. FACP	Theodore F. Hagerman M.D.
George W. Applegate M.D.	Douglas F. Johnstone M.D.
Richard Bloch M.D.	Wendy L. Kindig M.D.
Charles B. Carter M.D.	LeRoy H. King Jr. M.D. FACP
William H. Dick M.D. FACP	Mary A. Margolis M.D.
	Tim E. Taber M.D.

**1801 N. Senate Blvd., Suite 355
Indianapolis 46202
Tel: 317-924-8425**

By Physician Referral

Clinical Nephrology, Hemodialysis, Peritoneal Dialysis, Renal Transplantation, Metabolic Kidney Stone Disease, Hypertension, Fluid and Electrolyte Imbalance, Critical Care

HEMODIALYSIS

CHRONIC MAINTENANCE OUTPATIENT HEMODIALYSIS

DIALYSIS INSTITUTE OF ANDERSON
2629 Nichol Avenue
Anderson, Indiana 46011
317-649-0772

DIALYSIS INSTITUTE OF BEECH GROVE
3834 South Emerson Avenue
Indianapolis, Indiana 46203
317-787-3171

For further information contact
NEPHROLOGY & INTERNAL MEDICINE, INC.
1801 N. Senate Blvd., Suite #355
Indianapolis, Indiana 46202
317-924-8425

Outpatient renal consultation may be scheduled at any location.

HAND SURGERY

JOHN C. KLEIN, M.D.

Specializing in the diagnosis and treatment of hand, wrist, and forearm disorders.

2727 N. Pennsylvania St	317-925-1665
Indianapolis, IN 46205	Answered 24 hours

**Diplomate American Board of Orthopedic Surgery
with certificate of added qualifications in surgery of the hand.**

DOCTORS – This space is available.

For rates, write or call INDIANA MEDICINE,
322 Canal Walk, Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

DERMATOPATHOLOGY

DERMATOPATHOLOGY LABORATORY

Larry J. Buckel, M.D.
Robert M. Hurwitz, M.D.

Howard R. Gray, M.D.
William B. Moores, M.D.



Diplomates of the American Boards
of
Dermatology and Dermatopathology

Specializing in
Inflammatory Skin Diseases
and
Neoplasms of the Skin

9202 North Meridian Street
Suite 215

Approved for and Accept
Medicare and Medicaid
Assignment

Indianapolis, Ind. 46260
(317) 843-2204

UPS Mailers and Courier Service Available

PSYCHIATRY

Eugene G. Roach, M.D.
Executive/Medical Director



Anderson Center

of Saint John's

1-800-435-9143 or (317) 646-8114

- Comprehensive Psychiatric Treatment
- Separate Programs for Adolescents, Adults and Older Adults
- Program for Dual Diagnosis

NEUROLOGY

Shirley M. Mueller, M.D.
General Neurology

Practice Dedicated Toward Problems Associated With
Numbness-Weakness-Dizziness And Pain Including Headache

Testing Available

317-871-6000

Indianapolis

North: St. Vincent's Professional Bldg. #726

South: Community South Professional Bldg., Suite M

PERIPHERAL VASCULAR SURGERY



VASCULAR SURGERY, P.C.

Austin L. Gardner, M.D.
Malcolm B. Herring, M.D.
Daniel R. LeGrand, M.D.
David L. Madison, M.D.
Spencer F. Goodson, M.D.
Sajjad M. Hussain, M.D.

St. Vincent Professional Building
8402 Harcourt Road
Suite 613
Indianapolis, Indiana 46260
Telephone (317) 871-6400
TOLL FREE (800) 662-5367

Carmel Medical Center
13450 North Meridian Street
Suite 160
Carmel, Indiana 46032
Telephone (317) 573-7040
TOLL FREE (800) 446-0298

Vascular
Diagnostics
— Mobile
— Non-invasive
— Testing™



The Vascular Lab

**NONINVASIVE
VASCULAR TESTING**

The vascular lab offers a full spectrum of diagnostic vascular testing services, including the new addition of color computed sonography, supported by the entire team of:

John F. Ansbro, M.D. • Alan T. Marty, M.D. • H. Dan Adams, M.D.
Richard A. Murrell, M.D. • Daniel B. Daniels, M.D. • Jay Tuna, M.D.

Cardiovascular Surgery Inc.

350 West Columbia
Suite 350
Evansville, Indiana 47710
812-423-2395

■physicians' directory

ASTHMA & ALLERGY

FRANK WU, M.D.



DIPLOMATE,
AMERICAN BOARD
OF ALLERGY &
IMMUNOLOGY

St. Vincent Professional Building
8402 Harcourt Road, Suite 606
Indianapolis, Indiana 46260
(317) 872-4213

ORTHOPAEDIC SURGERY

JAMES L. KAISER, M.D.



- ORTHOPAEDIC SURGERY
- FRACTURES
- BACK SURGERY
- FOOT SURGERY
- ARTHROSCOPIC SURGERY

Certified American Board
Of Orthopaedic Surgery

5626 East 16th Street
Indianapolis, IN 46218

(317) 352-0176

OFFICE ANSWERS DAY & NIGHT

5626 E 16
82nd & Shadeland
If No Answer Call

352-0176
352-0176
543-6089

ONCOLOGY



Oncology Associates

Michael A. Cross, M.D.

Board Certified, Radiology (Therapeutic)

John R. Pancoast, M.D.

Board Certified, Internal Medicine
and Medical Oncology/Hematology

John F. Sacco, M.D.

Board Certified, Internal Medicine
and Radiology (Therapeutic)

Offering comprehensive cancer care, including:

- Cancer Detection
- Chemotherapy
- Radiation Therapy (Linear Accelerator)
- Biologic Therapy
- Education and Support Services
- Hospital, Home and Hospice Care

Dearborn County Hospital Professional Building
606 Wilson Creek Road, Suite 130
Lawrenceburg, Indiana 47025
(812) 537-1911

Oncology Associates' 16 physician members have additional offices in Cincinnati, Montgomery and Middletown, Ohio; and Crestview Hills, Kentucky. The practice offers outpatient care and clinics in 11 hospitals throughout the Tri-State area.

ONCOLOGY — HEMATOLOGY

**INDIANA ONCOLOGY HEMATOLOGY
CONSULTANTS**



1-800-ONC-HEME
1-800-662-4363

Central: 317-927-5770
St. Francis: 317-783-8509

ADULT ONCOLOGY HEMATOLOGY — CENTRAL OFFICE

1828 N. Illinois Street Indianapolis, IN 46202 927-5770

Laurence H. Bates, M.D.

Gregory W. Smith, M.D.

William M. Dugan, Jr., M.D.

William H. Bond, M.D.

Redmond P. Hogan, III, M.D.

PEDIATRIC ONCOLOGY HEMATOLOGY — CENTRAL OFFICE

1828 N. Illinois Street Indianapolis, IN 46202 927-5770

Arthur J. Provisor, M.D.

Deborah S. Provisor, M.D.

ADULT ONCOLOGY HEMATOLOGY — ST. FRANCIS OFFICE

1600 Albany — Medical Clinic Bldg. Beech Grove, IN 46107 783-8509

Redmond P. Hogan, III, M.D.

Randall C. Trowbridge, M.D.

Gregory W. Smith, M.D.

*Central Office Located in the Byram Gates Middleton House
Listed on the National Register of Historic Places*

RADIATION ONCOLOGY



Physicians:
ROGER ROBISON
TAE CHUNG
DAVID BELL

Radiation Oncology Services for Southwest Indiana

VINCENNES
Good Samaritan Hospital
(812) 885-3939

TERRE HAUTE
Regional Hospital
(812) 237-9326

ROGER ROBISON, M.D., F.A.C.P.
M.D. Anderson, 1980
Certified: Radiation
Oncology
Medical Oncology

TAE CHUNG, M.D.
Chicago Hines, V.A., 1976
Certified: Radiation
Oncology

DAVID BELL, M.D., Ph.D.
M.D. Anderson, 1981
Certified: Radiation
Oncology

RADIATION ONCOLOGY

TRI-STATE RADIATION ONCOLOGY

Evansville Cancer Center
Evansville, Indiana
(812) 474-1110



Welborn Cancer Center
Evansville, Indiana
(812) 426-8373

AL KORBA, M.D.; ALY RAZEK, M.D.
THOMAS HAYES, M.D.; AMR AREF, M.D.; SHANNON LAMB, M.D.

★ ★ ★ ★ ★

Tri-County Cancer Care Center
Jasper, Indiana
(812) 482-2212
DEV DAS SHETH, M.D.

Tri-County Cancer Care Center
Princeton, Indiana
(812) 386-6663
MOISES DOMINGO, M.D.

★ ★ ★ ★ ★

Olney Cancer Center
Olney, Illinois
(618) 392-3050
MOISES DOMINGO, M.D.

Harrisburg Oncology Associates
Harrisburg, Illinois
(618) 252-5126
MANJU GUPTA, M.D.

★ ★ ★ ★ ★

Radiation Oncology
Owensboro, Kentucky
(502) 926-7228
TRISTAN BRIONES, M.D.

Henderson Cancer Center
Henderson, Kentucky
(502) 827-0255
AMR AREF, M.D.

★ ★ ★ ★ ★

In Indiana 1-800-843-7117 • Out of Indiana 1-800-331-9294
24-hour answering service (812) 476-1367

TRANSPLANTATION

*Transplantation offers patients
with end-stage organ disease their only
opportunity for true rehabilitation...*

Methodist Transplant Center
24-hour referral: 800 772-7788



The Difference is Experience

P.O. Box 1367
1701 N. Senate Blvd.
Indianapolis, Indiana 46206

Heart Transplantation

Surgical Director: **Harold Halbrook, M.D.**
Surgeons: John Fehrenbacher, M.D.,
Daniel Beckman, M.D., David Hormuth, M.D.
Program Cardiologist: Douglas Pitts, M.D.

Kidney Transplantation Pancreas Transplantation

Surgical Director: **Brian Haag, M.D.**
Surgeons: Larry Stevens, M.D.,
Dale A. Rouch, M.D.
Program Nephrologist: Charles Carter, M.D.

Lung Transplantation

Surgical Director: **Harold Halbrook, M.D.**
Surgeons: John Fehrenbacher, M.D.,
Daniel Beckman, M.D., David Hormuth, M.D.
Program Pulmonologist:
Michael Niemeier, M.D.

Liver Transplantation

Surgical Director: **Dale A. Rouch, M.D.**
Surgeons: Larry Stevens, M.D.,
Brian Haag, M.D.
Program Pediatric Gastroenterologist:
Susan Maisel, M.D.
Program Hepatologist: Stephen C. Pappas, M.D.

Bone Marrow Transplantation

Co-Director: Luke Akard, M.D.
Co-Director: Jan Jansen, M.D., Ph.D.

Corneal Transplantation

Surgical Director: **Stephen Johnson, M.D.**

Tissue/Bone Bank

Surgical Director: **David A. Fisher, M.D.**

ORTHOPAEDIC SURGERY

PERFORMANCE



IN A HIGH-PERFORMANCE SPORTS CAR, THE SPOKES ARE AN INTEGRAL PART OF THE ENGINEERING. EACH INDIVIDUAL SPOKE IS STRONG, YET IT'S THE WAY THEY'RE INTERWOVEN THAT GIVES EXCEPTIONAL STRENGTH AND BALANCE.

THAT'S THE WAY IT IS AT ORTHOPAEDICS INDIANAPOLIS. EACH OF OUR 19 PHYSICIANS HAS UNIQUE INDIVIDUAL STRENGTHS AND SKILLS. THE ABILITY TO DRAW ON EACH OTHER'S SPECIAL EXPERTISE STRENGTHENS OUR CAPABILITIES AND ENHANCES OUR PERFORMANCE.

AS THE EXCLUSIVE PROVIDER OF RAPID AND EXTENSIVE ORTHOPAEDIC RECONSTRUCTIVE SURGERY FOR METHODIST HOSPITAL'S EMERGENCY MEDICINE AND TRAUMA CENTER, WE TREAT OVER 1,000 TRAUMA CASES A YEAR PROVIDING US WITH EXPERIENCE IN EVERY FACET OF ORTHOPAEDIC CARE. THAT'S WHY DOCTORS FROM ALL 50 STATES AND 11 FOREIGN COUNTRIES HAVE SOUGHT OUR HELP TREATING THEIR MOST COMPLEX CASES.

DONALD S. BLACKWELL, M.D.
F.R. BRUECKMANN, M.D., F.A.C.S.
ANTHONY R. LASICH, M.D.
WILLIAM O. IRVINE, M.D.
JOSEPH C. RANDOLPH, M.D.
DONALD E. RUSSELL, M.D.
MARK R. STEVENS, M.D.
TERRY R. TRAMMELL, M.D.
ANDREW J. VICAR, M.D.
VINCENT L. FRAGOMENI, M.D.
JOHN K. SCHNEIDER, M.D.
JOSEPH R. BAELE, M.D.
SANFORD S. KUNKEL, M.D.
DAVID A. FISHER, M.D.
D. KEVIN SCHEID, M.D.
MICHAEL F. COSCIA, M.D.
HENRY G. STEIN, M.D., F.A.C.S.
ORTHOPAEDIC SURGEONS
ROBERT C. GREGORI, M.D.
PHYSICAL MEDICINE & REHABILITATION

JOINT RECONSTRUCTION
TRAUMA
FRACTURE CARE
SPORTS MEDICINE
SCOLIOSIS
SPINAL SURGERY
SHOULDER SURGERY
HAND SURGERY
FOOT SURGERY
ARTHROSCOPIC SURGERY
PEDIATRIC ORTHOPAEDICS
ADULT ORTHOPAEDICS
ILIZAROV LIMB LENGTHENING
& DEFORMITY CORRECTION



**ORTHOPAEDICS
INDIANAPOLIS**

INDIANAPOLIS • DANVILLE
GREENCASTLE • SPEEDWAY
ZIONSVILLE
317-923-5352
1-800-223-3381

ORTHOPAEDICS & SPORTS MEDICINE

Hoosier Orthopaedics & Sports Medicine, P.C.

The Foot Program staff medically manages
common foot problems such as:

Ingrown Toenails
Mortons Neuroma
Hammer Toes
Bunions
Bunionette
Foot Strain
Soft Corns
Corns
Calluses
Planter Warts

Special emphasis on diabetic and rheumatoid
arthritis foot problems. The services of a
Pedicurist are available by appointment.

Office Answers Day and Night

13450 North Meridian Street, Suite 355, Carmel, Indiana 46032
(317) 575-2705

8330 Naab Road, Suite 234, Indianapolis, Indiana 46260
(317) 870-7075



Robert M. Palmer, M.D.

Frank B. Throop, M.D.

Robert T. Clayton, M.D.

Robert E. Cravens, M.D.

John E. Garber, M.D.

Thomas F. Trainer, M.D.

COMPREHENSIVE REHABILITATION

We're Working to Make Life Better

At Kokomo Rehabilitation Hospital, we're committed to only one specialized field – rehabilitation medicine.

This central focus means your patients receive the therapy and care needed to restore their lives to the fullest extent possible.



**Kokomo
Rehabilitation
Hospital**

Our newly opened, 60 bed hospital features sophisticated high tech equipment, a total barrier-free environment and highly trained therapists.

Give us a try. Your patients and you will be pleased with the results.

– William J. Lester, MD,
Medical Director

Bringing the Quality Back to Life for Patients Affected by:

Stroke • Traumatic Brain Injury • Spinal Cord Injury • Amputation • Orthopedic Disorders • Neurological Disorders • Arthritis • Back and Neck Injuries • Chronic Pain • Multiple Trauma • Return to Work
• Carpal Tunnel Syndrome and other Cumulative Trauma Disorders

829 Dixon Road • Kokomo, Indiana 46901
General Hospital Information
(317) 452-6700

For Referral or Admission Information
1-800-886-LIFE

A Continental Medical Systems Facility

DOCTORS

This space is available.

For rates, write or call

INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

MULTI-SPECIALTY GROUP PRACTICE

Addictionology
Allergy
Cardiovascular Diseases
Dermatology
Endocrinology
Family Practice
Gastroenterology
Gynecology
Hematology-Oncology
Internal Medicine
Neurology
Nephrology
Nuclear Medicine
Obstetrics
Ophthalmology
Orthopedics
Otolaryngology
Pediatrics
Psychiatry
Pulmonary Medicine
Rheumatology
Surgery
Urology



**Welborn
Clinic**

421 Chestnut Street
Evansville, Indiana 47713
(812)426-9440

Toll-free in Indiana:
1-800-521-0269

Westside Family Practice Ctr.
(812)429-1818

Welborn Clinic East
(812)474-7123

Welborn Clinic Highland
(812)426-9565

In Newburgh:
Welborn Clinic Newburgh
(812)853-7391

In Reo:
Reo Family Practice Center
(812)649-5061

■ from the museum

By the late 1800s, the compounding and dispensing of pills, lozenges, ointments and other medications became the pharmacist's primary responsibility, although economic necessity prompted some frontier physicians to continue to incorporate pharmacy into their medical practices.

Using a mortar and pestle or a mechanical pill mixer, the pharmacist began the production process by creating the appropriate pill mass. This paste consisted of the active ingredients and an excipient, an adhesive or absorbent substance or mixture that not only provided proper consistence but also ensured the pill-mass would retain the desired shape.

Joseph P. Remington, Ph.M., in *The Practice of Pharmacy: A Treatise on the Modes of Making and Dispensing Official, Unofficial and Extemporaneous Preparations, with Descriptions of Their Properties, Uses and Doses* (1889), recommended that an excellent excipient should consist of 4 oz. avoirdupois of glucose (white, pure), 1 oz. avoirdupois of glycerin, 90 grains of acacia (powdered, best) and 1 grain of benzoic acid. The pharmacist could omit the benzoic acid, used as an antiseptic, if he made the excipient frequently or in small quantities.

Having properly mixed the pill mass, the pharmacist transferred the mixture to a pill tile or a pill machine, on which the pharmacist rolled the pill mass into a pill cylinder of uniform thickness. Although steel spatulas existed by the late 1800s, the pharmacist typically preferred a wooden roller since its width sufficiently covered the entire pill mass during rolling, and therefore enabled

the pharmacist to eliminate any irregularities in the pill cylinder's thickness.

The pill tile enabled pharmacists to produce only a small number of pills at one time. Typically made of porcelain, this device contained a graduated scale by which the pharmacist could determine where to cut the pill cylinder to create the required number of pieces.

By contrast, the pill machine enabled the pharmacist to divide and cut large quantities of pills in one session. The device consisted of two hardwood pieces – a rolling board encased in metal to prevent warping and a roller that travelled along the length of that metal casing.

The top of the rolling board contained a brass plate with hemispherical grooves that corresponded exactly to a matching plate underneath the roller. Using the handles on the roller, the pharmacist would divide the pill cylinder by applying pressure downward as he moved the roller backwards along the rolling board. After completing the task, the pharmacist then divided the contents in each groove into the required number of pills.

After cutting on the pill tile or with the pill machine, the pharmacist either individually rolled the pills between his finger or used a pill finisher to impart the desired spherical shape. Once dried, the pills were coated to mask their taste and polished to complete the process.

By the turn of the century, pharmaceutical companies began to replace the pharmacist as the primary manufacturers of pills and other medications. In *A Treatise on Pharmacy for Students and Pharmacists* (1895), Charles Caspari Jr., Ph.G., documented this trend when he wrote, "The opportunities for a practical acquaintance with the details of [pharmacy] work are growing less day by day, owing to the untiring efforts of manufacturers to induce physicians to specify factory-made pills on their prescriptions."

The Indiana Medical History Museum will open an exhibit on the history of pharmacy in March. Visitors may access the museum, located on the grounds of Central State Hospital in Indianapolis, from the museum's entrance at 3045 W. Vermont St. or the hospital's entrance on Warman Street. □



The pill-machine used by pharmacists consisted of two hardwood pieces – a rolling board encased in metal to prevent warping and a roller that travelled along the length of that metal casing.

■ cme calendar

St. Vincent Hospital

St. Vincent Hospital and Health Care Center in Indianapolis will sponsor these CME courses:

- Mar. 18** - Basic Colposcopy, St. Vincent Hospital and Health Care Center, Indianapolis
- Mar. 20** - Third Annual Geriatric Conference: Diagnosis and Treatment of Elderly Fallers, Radisson Plaza Hotel, Indianapolis.
- Apr. 10-11** - Joseph C. Finneran Lectureship, St. Vincent Hospital and Health Care Center, Indianapolis.
- Apr. 14** - Neonatal Advanced Life Support, St. Vincent Hospital and Health Care Center, Indianapolis.
- Apr. 25-26** - 10th Annual Spring Seminar in Dermatopathology, Cooling Auditorium, St. Vincent Hospital and Health Care Center, Indianapolis.

For more information, call Beth Hartauer, (317) 871-3460.

Indiana University

The Indiana University School of Medicine will sponsor these courses:

- Mar. 25-27** - 1992 Symposium on Breast Imaging, Radisson Plaza Hotel, Indianapolis.
- Apr. 23-24** - 15th Annual Arthur B. Richter Conference, University Place Conference

- Apr. 29** - Headache Symposium, University Place Conference Center, Indianapolis.
- May 3-6** - Update Workshop in Echocardiography, University Place Conference Center, Indianapolis.
- May 8** - Phase II - Advanced Management of HIV Disease, Radisson Plaza Hotel, Indianapolis.
- May 15-16** - New Horizons in the Practice of Medicine and Medical Alumni Weekend, University Place Conference Center, Indianapolis.
- May 28-31** - Rejuvenation of Face 1992, University Place Conference Center, Indianapolis.

For more information, call (317) 274-8353.

Indpls. Regional Heart Center

The Indianapolis Regional Heart Center at St. Francis will sponsor this course:

- Mar. 18** - A Woman's Heart, Holiday Inn Union Station, Indianapolis.

For more information, call Marsha Breen, (317) 783-2776.

Multidisciplinary Child Care

The Indiana University School of Medicine will sponsor the 27th Annual Indiana Multidisciplinary Child Care Conference May 13 and 14 at the Holiday Inn Union Station in Indianapolis.

Topics will include pediatric

infectious disease, neurology, rheumatology, behavior disorders, allergy and asthma, gastroenterology and nutrition.

For registration information, write Dr. Richard Schreiner, Department of Pediatrics, attn: Mary Ann Underwood, IU School of Medicine, Riley Hospital, Room 5867, 702 Barnhill Drive, Indianapolis, IN 46202-5225.

Cardiovascular Medicine

Rush Presbyterian-St. Luke's Medical Center will sponsor the Second Annual Review and Update Course in Cardiovascular Medicine May 7 through 9 at the Hotel Inter-Continental in Chicago.

The two and a half-day course will provide a comprehensive update in the diagnosis, monitoring and management of cardiovascular disease.

For more information, call Svetlana Lisanti, (201) 385-8080.

University of Michigan

The University of Michigan Medical School will sponsor these courses:

- Apr. 2-3** - Challenges and Changes: Obstetrics and Gynecology in the 1990s.
- Apr. 8-10** - Ultrasound in Obstetrics and Gynecology.
- Apr. 11** - Practical ID for the Practicing Doc.

These courses will be held at The Towsley Center in Ann Arbor, Mich. For details, call Angela Stewart, (313) 763-1400. □

Marion Merrell Dow has announced that Cardizem® CD (diltiazem HCl) has been released for U.S. marketing. The once-a-day capsules for treating hypertension are available in 180-mg, 240-mg and 300-mg capsules.

Syntex Corp. has received approval from the U.S. Food and Drug Administration to market Toradol® Oral (ketorolac tromethamine), an alternative to narcotics. It acts peripherally at the site of pain and does not act on the central nervous system. The new oral formula is expected to be available this month.

Hewlett-Packard Co. has introduced a family of sterile and non-sterile disposable blood pressure cuffs for adult, pediatric and neonatal applications on HP monitors. The disposable cuffs help minimize the potential for cross contamination among patients. All cuffs have a single hose for connections to the monitor and have an arterial guide to position the cuff for readings.

Marion Merrell Dow and ALZA Corp. have received approval from the U.S. Food and Drug Administration to market Nicoderm®, the first nicotine transdermal patch for smoking cessation. The Nicoderm system

delivers nicotine over 24 hours, thus reducing the nicotine craving many smokers experience. The effectiveness of Nicoderm therapy has been demonstrated in two studies including more than 700 patients.

Abbott Laboratories has announced that its new oral antibiotic, Biaxin™, is now available. Biaxin is used for treating respiratory tract and skin and skin structure infections. In clinical trials, Biaxin was as effective as erythromycin in the outpatient management of community-acquired pneumonia caused by *Streptococcus pneumoniae* and *Mycoplasma pneumoniae*. However, Biaxin was better tolerated with fewer side effects, including gastrointestinal side effects reported with erythromycin.

American Hospital Publishing has released *The Health Care Manager's Guide to Continuous Quality Improvement*. The book is directed to department directors, physician chiefs, improvement team leaders and facilitators, administrators and committee chairmen. It can be ordered from American Hospital Association Services, P.O. Box 92683, Chicago, IL 60675-2683 for \$49.95 (AHA members \$39.95). Include \$7.95 (AHA members \$6.95) for ship-

ping and handling.

The American Geriatrics Society has released an expanded edition of Geriatrics Review Syllabus: *A Core Curriculum in Geriatric Medicine (GRS)*. The syllabus is a comprehensive review of geriatric medicine with 63 contributing authors. To order the three-volume syllabus, call Patricia Miller at (212) 308-1414.

Marlow Surgical Technologies has introduced a new Reddick-Saye needle driver for advanced laparoscopic procedures. The 5 mm needle driver is available in right-handed, left-handed and universal configurations. It was designed to accommodate curved needles and to aid in uprighting the needle in the abdomen for more efficient suturing.

Syntex Corp. has received approval from the U.S. Food and Drug Administration to market Ticlid® (ticlopidine hydrochloride), used to reduce the risk of thrombotic stroke in patients who have experienced stroke precursors and patients who have had a thrombotic stroke. Ticlid is the first prescription antiplatelet agent to be approved for marketing in the United States. □

■ obituaries

Amos Arney, M.D.

Dr. Arney, 69, a Michigan City general practitioner, died Dec. 10 at Memorial Hospital in Michigan City.

He was a 1952 graduate of the Indiana University School of Medicine and served with the U.S. Armed Forces.

Dr. Arney was instrumental in establishing Michigan City's Open Door Health Center, where he also was a volunteer. He helped establish Operation Head Start and volunteered for the county's Immunization Clinic and the county Emergency Medical Services program. He was one of the founders of the Michigan City Medical Group and was a diplo-

mate of the American Board of Family Practice. In 1985, he was honored as Michigan City's Humanitarian of the Year.

Robert E. Chattin, M.D.

Dr. Chattin, 72, a retired Loogootee family practitioner, died Nov. 21 at Daviess County Hospital.

He was a 1943 graduate of the Indiana University School of Medicine and a veteran of World War II.

Dr. Chattin was a family practitioner in Loogootee from 1947 to 1985. He served on the Loogootee School Board 13 years.

Delfin P. David, M.D.

Dr. David, 55, a Kokomo emergency medicine specialist, died Nov. 8.

He was a 1961 graduate of the Institute of Medicine, Far Eastern University, Philippines.

Dr. David was a member of the Howard County Medical Society.

Kenneth L. Glasser, M.D.

Dr. Glasser, 48, an Indianapolis cardiovascular surgeon, died Jan. 11.

He was a 1968 graduate of the University of Miami School of Medicine and an Army veteran of the Vietnam War.

Dr. Glasser practiced at St.

In memoriam: **Malcolm O. Scamahorn, M.D.**



Dr. Scamahorn

Dr. Scamahorn, 73, a past president of the Indiana State Medical Association and a retired Pittsboro family practitioner, died Dec. 16.

He was a 1943 graduate of the Indiana University School of Medicine, which in 1987 named him a distinguished alumnus. From 1945 to 1946, he was an Army Medical Corps captain and chief of medicine at the base and field hospital in Salzburg, Austria.

Dr. Scamahorn was a family practitioner in Pittsboro 40 years and for many years was the town's only doctor. He was a charter member and past president of the Indiana Academy of Family Physicians and a charter member and fellow of the American Academy of Family Physicians.

He served the ISMA as president in 1971 and also as assistant

treasurer and AMA delegate. He was a member of the AMA Council on Medical Services, several AMA committees and the AMA speaker's bureau. From 1972 to 1978, he was a member and treasurer of the Indiana Board of Medical Licensure.

Dr. Scamahorn was appointed to the U.S. Department of Health and Human Services Task Force on Long-Term Health Care Policies in 1986. He served as a consultant for Blue Cross and Blue Shield of Indiana from 1986 to 1989. He was Hendricks County deputy coroner from 1950 to 1965.

He was the first chief of staff at Hendricks County Hospital and also was on the staffs at Methodist and St. Vincent hospitals in Indianapolis. He had served as president of the Hendricks County Board of Health and the I.U. School of Medicine Alumni Association. □

Vincent Hospital and was a partner in Shumacker, Isch, Jolly, Fitzgerald, Fess and Glasser M.D.s Inc. He was a co-founder of the Community Foundation of Boone County and served on its board of directors. He was a member of the American College of Surgeons, The Society of Thoracic Surgeons and the American College of Cardiology.

Frederick A. Loop, M.D.

Dr. Loop, 84, a retired Lafayette surgeon, died Nov. 26 at St. Elizabeth Hospital Medical Center in Lafayette.

He was a 1930 graduate of the University of Michigan Medical School and was a lieutenant in the Naval Reserves during World War II.

Dr. Loop had a private surgery practice in Lafayette from 1933 until he retired in 1973. After retiring, he was medical director at the Indiana Veterans Home five years. He was a diplomate of the American Board of Surgery, a fellow in the American College of Surgeons and a past president of the Tippecanoe County Medical Society. He served on the staffs and was past president of both St. Elizabeth Hospital Medical Center and Home Hospital.

James R. Mensch, M.D.

Dr. Mensch, 68, a retired Fort Wayne anesthesiologist, died Jan. 3 at his home.

He was a 1951 graduate of the Indiana University School of Medicine and an Army Medical

Corps veteran of World War II.

He had been on the staff of Parkview Memorial Hospital since 1953. He was a member of Trout Unlimited and the Federation of Fly Fishers.

Herschel C. Moss, M.D.

Dr. Moss, 76, Indianapolis, died Dec. 19.

He was a 1950 graduate of the Indiana University School of Medicine.

Dr. Moss had been a general surgeon with the U.S. Air Force. He retired as a colonel in 1987.

Tracy C. Owens, M.D.

Dr. Owens, 89, a retired Indianapolis psychiatrist, died Dec. 27 at St. Vincent Hospital in Indianapolis.

He was a 1929 graduate of the Wayne State University School of Medicine.

Dr. Owens was affiliated with the Veterans Administration from 1931 to 1942 and was a psychiatrist in the Air Force from 1942 to 1946, leaving as a lieutenant colonel. He had a private practice in Indianapolis 23 years and retired in 1969.

Robert M. Stoltz, M.D.

Dr. Stoltz, 71, a Valparaiso family practitioner, died Jan. 3.

He was a 1953 graduate of the Indiana University School of Medicine and a U.S. Marine Corps veteran of World War II.

Dr. Stoltz opened his practice in Valparaiso in 1955 and was on the staff of Porter Memorial Hos-

pital. He also served as the Valparaiso High School football team physician for 39 years and the Valparaiso University team physician for 30 years. He was named an honorary lifetime member of the National Athletic Trainers Association in 1990 and was inducted into the Valparaiso High School Athletic Hall of Fame in November 1991.

Gary C. Williams, M.D.

Dr. Williams, 47, an Indianapolis allergist and immunologist, died Dec. 4 at St. Vincent Hospital.

He was a 1970 graduate of the University of Illinois College of Medicine.

Dr. Williams owned East Side Medical Center 15 years. He had been chief of admitting for the West 10th Street Division of the Roudebush VA Medical Center. He was a member of the American Academy of Allergists.

Jonathan G. Yoder, M.D.

Dr. Yoder, 87, a Goshen family practitioner, died Dec. 16 in Greencroft Nursing Center in Goshen.

He was a 1933 graduate of the Indiana University School of Medicine.

Dr. Yoder was a medical missionary to India and Nepal with the Mennonite Board of Mission more than 30 years. He was on the staff at Goshen General Hospital and had a private practice in Middlebury. He also had been an emergency physician at Goshen and LaGrange hospitals. □



Dr. Lanning

Dr. R. Adrian Lanning and the late Dr. James A. Dillon received the first Physician Distinguished Service Awards from

Riverview Hospital in Noblesville. Dr. Lanning, a former ISMA trustee, is a family practitioner. Dr. Dillon served as president of the Riverview medical staff.

Dr. Terry R. Trammell, an Indianapolis orthopaedic surgeon, was honored by the American Auto Racing Writers and Broadcasters Association at its All-American Awards Banquet; he is director of Safety Team Medical Services for Championship Auto Racing Teams and for almost 20 years has treated some of the top drivers in auto racing.

Dr. Michael H. Fritsch, an otolaryngologist at the Indiana University Medical Center, has authored his second book, *Atlas of Paranasal Sinus Surgery*.

Several physicians from The Indiana Hand Center in Indianapolis have participated in specialty society activities. Dr. Hill Hastings II attended the German Speaking Hand Society meeting in Berne, Switzerland, as guest of honor; he also was among the teaching faculty at the Davos Hand Course, sponsored by the AO/ASIF Foundation, in Davos, Switzerland. Dr. Richard S. Idler and Dr. Hastings were co-chairmen of the American Society for Surgery of the Hand Regional Review Course in Indianapolis. The entire surgical staff of the hand center served as faculty members for the course. Dr. Thomas J. Fischer and Dr. Hastings were faculty members at the

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

November 1991

Acosta, Constancio B., Hobart
Beeson, William H., Indianapolis
DePalma, Bruno, Lawrenceburg
Dennison, Kumpol, Merrillville
Diotallevi, Gary H., Newburgh
Driehorst, William L., Beech Grove
Gluckin, James E., Elkhart
Hanke, C. William, Indianapolis
Link, William C., Bloomington
Malachowski, Robert M., Indianapolis
Michael, Isaac E., Indianapolis
Obando, Guillermo, Bedford
Olivier, Henry F., Indianapolis
Randolph, Geoffrey M., Fort Wayne
Silver, Richard A., Indianapolis
Whitaker, Hiram J., Beech Grove
Young, Fredric D., Munster

December 1991

Allen, Donald R., Evansville
Biegel, Angenieta A., Indianapolis
Brennan, Thomas F., Lafayette
Byllesby, Joyce E., Washington
Carey, John A., Gary
Clausen, Robert W., South Bend
Conway, Thomas J., Terre Haute
Dye, William E., Oakland City
Ferguson, James F., Bloomington
Fulton, William H., Indianapolis
Heaton, Gregory E., Madison
McClure, Richard O., Carmel
Mishkin, Marvin E., Elkhart
Rhynearson, William R., Indianapolis
Swanson, Richard T., Evansville
Thompson, Samuel R., Fort Wayne
Van Buskirk, Edmund L., Lafayette

American Academy of Orthopaedic Surgeons course on "Upper Extremity Fractures and Trauma Management Decisions" in San Diego, Calif. Dr. William B. Kleinman was the keynote speaker for the annual meeting of the Argentine Hand Society in Buenos Aires, Argentina.

Dr. John H. Abrams, an Indianapolis ophthalmologist, was named a fellow of the American College of Surgeons.

Dr. Tod C. Huntley of Indianapolis was selected for a three-year term on the American Academy of Otolaryngology/Head and Neck Surgery's Sleep Disorders Committee.

Dr. Stephen W. Perkins, an Indianapolis facial plastic and reconstructive surgeon, was chairman of the Midwestern Region

Scientific Program and Socioeconomic Roundtable of the American Academy of Facial Plastic and Reconstructive Surgery. He moderated a panel discussion on "Aesthetic and Airway Considerations in Correction of Symptomatic Airway Obstructions in Secondary Rhinoplasty." He also spoke on "Evaluation of Herpes Prophylaxis in Perioral Chemical Peel and Dermabrasion" and was a panelist on a discussion of "Difficult Cases in Aesthetic Facial Rejuvenation."

Dr. Robert C. Oehler has become affiliated with Nasser, Smith & Pinkerton Cardiology, based in Indianapolis; he has a cardiology and internal medicine practice in Brazil, Ind.

Dr. George W. Hicks, an Indianapolis otolaryngologist-

otologist, presented a paper on "Perilymph Fistula and Meniere's Disease: A Treatment Dilemma" at the meeting of the American Laryngological, Rhinological and Otological Society in Cleveland. He also has been appointed to the Indiana State Board of Hearing Aid Dealer Examiners by Gov. Evan Bayh.

Dr. Stephen H. Kliman, an Indianapolis cardiologist, was named a fellow of the Society for Cardiac Angiography and Interventions.

Dr. H.O. Hickman Jr., an Indianapolis cardiologist, was elected a fellow of the American College of Physicians.

Drs. William C. Sando and Christopher S. Jones have opened a plastic and reconstructive surgery office at 6920 Parkdale Place in Indianapolis.

Dr. Carl F. Conwell, a Terre Haute family practitioner, was named Vigo County health officer.

Dr. Charles E. Helms, a Munster surgeon, was elected president of the medical staff of St. Margaret Hospital and Health Centers in Hammond.

Dr. Roland M. Kohr, a Terre Haute pathologist, was named chief of staff at Terre Haute Regional Hospital.

Dr. John A. Moss, an Anderson otolaryngologist, was elected president of the medical staff at St. John's Health Care Corp. in Anderson.

Dr. Mark O. Lynch of Sullivan was named a fellow of the American College of Surgeons.

Dr. Barton C. Bridge has retired after 28 years as a family practitioner in Lafayette.

Dr. Andrew C. Thieneman of Evansville was among 18 cyclists who participated in the Pacific-Atlantic Transcontinental Tour '91, a non-competitive bicycle ride from Huntington Beach, Calif., to

Savannah, Ga. He is a specialist in endocrinology and metabolism.

Dr. George O. Parks has retired after 43 years as a family practitioner in Hartford City; he will continue as county health officer.

Dr. George B. Keenan, an Indianapolis family practitioner, received the Outstanding Alumni Award from the Boys and Girls Club of Indianapolis; the Keenan-Stahl Club on the Indianapolis southside is co-named in his honor.

Dr. Gerald T. Keener Jr., an Indianapolis ophthalmologist, was elected president of the board of the Indiana Society to Prevent Blindness.

Dr. Frank P. Lloyd Jr., an Indianapolis oncologist, was appointed chairman of the Little Red Door Cancer Agency's Black Cancer Awareness Coalition.

Dr. Robert J. Warren, a Richmond pediatrician, is the co-author of *So Your Child Has a Fever*, a book published for migrant farm workers in South Carolina.

Dr. George H. Rawls, an Indianapolis surgeon and past president of ISMA, was honored at a black-tie gala sponsored by Living Legends, which specializes in honoring leaders in the Indianapolis black community.

Dr. Edward R. Bush was named medical director of St. John's Children's Clinic in Anderson.

Dr. Keim T. Houser of South Bend was elected vice chairman of the Indiana Section of the American College of Obstetricians and Gynecologists.

Dr. John H. Mahon was named medical director of St. Joseph's Medical Center's Hand Clinic in South Bend.

Dr. Bradley C. Black, a Jeffersonville ophthalmologist, traveled to Japan last December to

demonstrate the cataract removal surgery procedure known as hydrosonics.

Dr. Emmett C. Pierce, a retired Indianapolis pathologist, was elected president of the Sertoma Club of East Indianapolis.

Dr. Otis Bowen, former governor of Indiana and former U.S. Secretary of Health and Human Services, was named the 1992 Arthritis Foundation honorary spokesman.

Dr. Kumpol Dennison, a Merrillville surgeon, was named president of the medical staff of Methodist Hospitals in Gary.

Dr. Andrew F. Marciniak, a pathologist, was elected president of the medical staff at Community Hospital in Anderson; **Dr. Joseph P. Porcaro**, a radiologist, was elected chief of staff.

Dr. Timothy R. Chamberlain, a Columbia City surgeon, was named a fellow of the American College of Surgeons. □

New ISMA members

Paul A. Angermeier, M.D., Indianapolis, anatomic/clinical pathologist.

Keith Atassi, M.D., Valparaiso, cardiovascular diseases.

Mohinder S. Badyal, M.D., Logansport, pediatrics.

G. David Bojrab, M.D., Fort Wayne, family practice.

Randall L. Braddom, M.D., Indianapolis, physical medicine and rehabilitation.

Robert D. Cagle, D.O., Madison, otolaryngology.

Carey D. Chisholm, M.D., Zionsville, emergency medicine.

Daniel J. Cumiskey, M.D., Fort Wayne, orthopaedic surgery.

Gary D. Davis, M.D., Fort Wayne, family practice.

Mrudula B. Desai, M.D., Princeton, obstetrics and gynecology.

■ people

James L. Dunn, M.D., Muncie, internal medicine.

Michael R. Engle, D.O., Fort Wayne, family practice.

Angelita V. Fontanilla, M.D., Greensburg, pediatrics.

Robert A. Goldstrom, M.D., Fort Wayne, anesthesiology.

Linda B. Guis, M.D., Columbus, pediatrics.

Peter S. Harvey, M.D., Fort Wayne, orthopaedic surgery.

Robert C. Hathaway, M.D., Fort Wayne, family practice.

Timothy Hodgini, D.O., Fort Wayne, family practice.

Mark A. Hoitink, M.D., Fort Wayne, family practice.

Debra J. Holmes, M.D., Franklin, pediatrics.

Ronald E. Jamerson, M.D., Munster, otolaryngology.

David A. Johnson, M.D., Fort Wayne, family practice.

Michael W. Kane, M.D., Indianapolis, psychiatry.

David M. Keller, M.D., Hagerstown, family practice.

Bernard P. Kemker Jr., M.D., Santa Claus, general surgery.

Diane M. Kolody, M.D., Franklin, family practice.

Carolyn R. Le Cour, M.D., Manhattan, Ill., internal medicine.

Kurt A. Maddock, M.D., Vincennes, general surgery.

Gary M. Mailman, M.D., Carmel, emergency medicine.

Manolo Manalo, M.D., Fort Wayne, family practice.

Uma Monga, M.D., Valparaiso, radiation oncology.

Paul E. Page, D.O., Seymour, family practice.

David S. Parks, M.D., Frankfort, family practice.

Joseph D. Phillips, M.D., Indianapolis, emergency medicine.

Robert J. Porte, M.D., Portage, family practice.

Tiong-Oen Pouw, M.D., Shelbyville, general surgery.

Ronald A. Raelson, M.D., Valparaiso, family practice.

Kevin A. Rahn, M.D., Fort Wayne, orthopaedic surgery.

Jose L. Ramirez, M.D., Munster, psychiatry.

Mohan K. Rao, M.D., Fort Wayne, otolaryngology.

Neil M. Richman, M.D., Fort Wayne, orthopaedic surgery.

Phillip A. Ross, M.D., Madison, general practice.

Jeanne M. Rowe, M.D., Fort Wayne, internal medicine.

Thomas P. Ryan, D.O., Fort Wayne, cardiovascular diseases.

Steven M. Samuels, M.D., Indianapolis, internal medicine.

Barbara J. Schroeder, M.D., Fort Wayne, ophthalmology.

John K. Shekleton, M.D., Indianapolis, gastroenterology.

David G. Short, D.O., Logansport, otolaryngology.

Nehal Singh, M.D., Fort Wayne, family practice.

Kevin T. Smith, M.D., Fort Wayne, family practice.

Timothy M. Snyder, M.D., Frankfort, pediatrics.

Andrew J. Sonderman, M.D., Fort Wayne, family practice.

Robert W. Stevenson, M.D., Muncie, internal medicine.

Anthony S. Tilmans, M.D., Muncie, radiation oncology.

Karen A. Tisinai, M.D., Indianapolis, general surgery.

Jay M. Veenendaal, M.D., Muncie, radiology.

David W. Vormorh, M.D., Fort Wayne, family practice.

Marilyn V. Whitney, M.D., Warsaw, family practice.

Carlos K. Woodward, M.D., Carmel, orthopaedic surgery.

Carol W. Wooldridge, D.O., Richmond, orthopaedic surgery.

William R. Yee, M.D., Warsaw, psychiatry.

Residents

Mark E. Bauman, M.D., Indianapolis, anatomic/clinical pathology.

Kevin W. Bozarth, M.D., Indianapolis, anesthesiology.

John S. Bradley, M.D., Indianapolis, emergency medicine.

Phillip R. Kingma, M.D., South Bend, family practice. □

OFFICERS

President — C. Dyke Egnatz, Schererville
 Pres.-elect — William H. Beeson, Indianapolis
 Immediate Past Pres — Michael O. Mellinger, LaGrange
 Executive Director — Richard R. King, Indianapolis
 Treasurer — John A. Biral, Evansville
 Asst. Treasurer — Timothy Brown, Crawfordsville
 Speaker — William C. Van Ness II, Summitville
 Vice Speaker — William E. Cooper, Columbus

EXECUTIVE COMMITTEE

*C. Dyke Egnatz, Schererville
 William H. Beeson, Indianapolis
 Michael O. Mellinger, LaGrange
 Peter Winters, Indianapolis
 John A. Biral, Evansville
 Timothy Brown, Crawfordsville
 Alfred Cox, South Bend
 Jerome Melchior, Vincennes
 William C. Van Ness II, Summitville
 William E. Cooper, Columbus

TRUSTEES (Terms end in October)

District

1 — Bruce Romick, Evansville (1992)
 2 — Jerome E. Melchior, Vincennes (1993)
 3 — Gordon L. Gutmann, Jeffersonville (1994)
 4 — Arthur C. Jay, Lawrenceburg (1992)
 5 — Fred E. Haggerty, Greencastle (1993)
 6 — Ray Haas, Greenfield (1994)
 7 — Donna J. Meade, Indianapolis (1992)
 7 — John M. Records, Franklin (1993)
 *7 — Peter L. Winters, Indianapolis (1994)
 8 — John V. Osborne, Muncie (1993)
 9 — Stephen Tharp, Frankfort (1994)
 10 — Nicholas L. Polite, Hammond (1992)
 11 — Jack W. Higgins, Kokomo (1993)
 12 — John R. Thomas, Fort Wayne (1994)
 13 — Alfred C. Cox, South Bend (1992)
 RMS — Rick Robertson, Indianapolis (1992)
 MSS — Andre Stovall, Indianapolis (1992)
 *Chairman

ALTERNATE TRUSTEES (Terms end in October)

District

1 — Barney R. Maynard, Evansville (1994)
 2 — James P. Beck, Washington (1992)
 3 — John H. Seward, Bedford (1992)
 4 — Robert L. Forste, Columbus (1994)

5 — Roland M. Kohr, Terre Haute (1994)
 6 — Howard C. Deitsch, Richmond (1992)
 7 — Ronald G. Blankenbaker, Indianapolis (1994)
 7 — Bernard J. Emkes, Indianapolis (1992)
 7 — Charles O. McCormick III, Greenwood (1993)
 8 — Susan K. Pyle, Union City (1994)
 9 — Robert I. Darnaby, Rensselaer (1992)
 10 — Frank M. Sturdevant, Valparaiso (1994)
 11 — Laurence K. Musselman, Marion (1992)
 12 — Charles M. Frankhouser, Fort Wayne (1992)
 13 — Richard J. Houck, Michigan City (1994)
 RMS — Carla Brumbaugh, Indianapolis (1992)
 MSS — Ruchir Sehra, Indianapolis (1992)

AMA DELEGATES (Terms end Dec. 31)

Marvin F. Priddy, Fort Wayne (1993)
 John D. MacDougall, Beech Grove (1993)
 Herbert Khalouf, Marion (1993)
 John A. Knot, Lafayette (1992)
 Alvin J. Haley, Carmel (1992)
 George T. Lukemeyer, Indianapolis (1992)

AMA ALTERNATE DELEGATES (Terms end Dec. 31)

Michael O. Mellinger, LaGrange (1993)
 George Rawls, Indianapolis (1993)
 Richard L. Reedy, Yorktown (1993)
 Shirley Thompson Khalouf, Marion (1992)
 Max N. Hoffman, Covington (1992)
 Edward L. Langston, Indianapolis (1992)

DISTRICT OFFICERS AND MEETINGS

1 — Pres: Richard A. Tibbals, Evansville
 Secy: Rex H. Ragsdale, Evansville
 Annual Meeting: May 21, 1992
 2 — Pres: Paul Daluga, Linton
 Secy: Frederick R. Ridge, Jr., Linton
 Annual Meeting: May 14, 1992
 3 — Pres: Stephen R. Havens, Jeffersonville
 Secy: Olegario J. Ignacio, Jeffersonville
 Annual Meeting: May 20, 1992
 4 — Pres: Robert L. Forste, Jr., Columbus
 Secy: Jeffery C. Hagedorn, Columbus
 Annual Meeting: May 6, 1992
 5 — Pres: James R. Rudolph, Greencastle
 Secy: Peggy Sankey-Swain, Rockville
 Annual Meeting: May 28, 1992
 6 — Pres: Robert W. Martlen, Connersville
 Secy: William H. Toedebusch, Richmond
 Annual Meeting: May 13, 1992

7 — Pres: Bernard J. Emkes, Indianapolis
 Secy: H. Marshall Trusler, Greenfield
 Annual Meeting: To be announced
 8 — Pres: Robert J. Helm, Elwood
 Secy: Gary Brazel, Anderson
 Annual Meeting: June 3, 1992
 9 — Pres: Robert E. Darnaby, Rensselaer
 Secy: Stephen D. Tharp, Frankfort
 Annual Meeting: June 10, 1992
 10 — Pres: Filemon P. Lopez, Dyer
 Secy: Barron M. Palmer, Hammond
 Annual Meeting: June 17, 1992
 11 — Pres: Regino Urgena, Marion
 Secy: Frederick C. Poehler, La Fontaine
 Annual Meeting: Sept. 16, 1992
 12 — Pres: William Aeschliman, Fort Wayne
 Secy: Joseph Manthey, Bluffton
 Annual Meeting: Sept. 17, 1992
 13 — Pres: David Haines, Warsaw
 Secy: John W. Schurz, South Bend
 Annual Meeting: Sept. 9, 1992

COMMISSION CHAIRMEN

Constitution and Bylaws
 Helen F. Czenkusch, Indianapolis
Legislation
 Eugene G. Roach, Anderson
Physician Assistance
 Robert Nelson, South Bend
Medical Services
 Dallas E. Coate, Lebanon
Medical Education
 James E. Carter, Indianapolis
Sports Medicine
 Ronald G. Blankenbaker, Indianapolis

COMMITTEE CHAIRMEN

Medical Malpractice (Ad Hoc)
 George T. Lukemeyer, Indianapolis
Grievance
 Richard B. Schnute, Indianapolis
Indiana Medical Foundation
 Frank B. Ramsey, Indianapolis

CHAIRMEN OF ISMA SPECIALTY SECTIONS

ALLERGY

Paul D. Isenberg, Indianapolis

ANESTHESIOLOGY

Stephen F. Dierdorf, Indianapolis

CUTANEOUS MEDICINE

Peter L. Winters, Indianapolis

DIRECTORS MEDICAL EDUCATION

Glenn Bingle, Indianapolis

EMERGENCY MEDICINE

Thomas C. Madden, Greenwood

FAMILY PRACTICE

Dallas E. Coate, Lebanon

INTERNAL MEDICINE

Neil Irick, Indianapolis

MEDICAL DIRECTORS AND STAFF PHYSICIANS OF NURSING FACILITIES

Larry G. Cole, Yorktown

NEUROLOGICAL SURGERY

Marvin R. Bernard, Merrillville

NEUROLOGY

Charles A. Bonsett, Indianapolis

NUCLEAR MEDICINE

Mike Mullinix, Indianapolis

OBSTETRICS & GYNECOLOGY

Philip N. Eskew Jr., Carmel

OPHTHALMOLOGY

D. Dean Cofield, Bloomington

ORTHOPAEDIC SURGERY

James G. Buchholz, Fort Wayne

OTOLARYNGOLOGY, HEAD & NECK SURGERY

William F. Cooper, Columbus

PATHOLOGY & FORENSIC MEDICINE

Joyce Byllesby, Washington

PEDIATRICS

Charlene Graves, Indianapolis

PHYSICAL MEDICINE AND REHABILITATION

Robert Gregori, Indianapolis

PREVENTIVE MEDICINE AND PUBLIC HEALTH

Gary A. Babcoke, Chesterton

PSYCHIATRY

Patricia Sharpley, Indianapolis

RADIOLOGY

Gonzalo T. Chua, Indianapolis

SURGERY

Robert Lempke, Indianapolis

UROLOGY

Rodney A. Mannion, LaPorte

ISMA KEY STAFF

Richard R. King, *Executive Director*
 Adele Lash, *Director of Operations/Communications*
 Mike Abrams, *Director of Marketing/Legislation*
 John Wilson, *Director of Administration*
 Ronald Dyer, *General Counsel*
 Susan Grant, *Executive Assistant*
 Richard Ryan, *Field Services (Northern)*
 Bob Sullivan, *Field Services (Central)*
 Janna Kosinska, *Field Services (Southern)*
 Barbara Walker, *Reimbursement Coordinator*
 Marvona Welsh, *Reimbursement Coordinator*
 Tom Martens, *Members Health Insurance*
 Tina Sims, *INDIANA MEDICINE*

Where can you find medical specialty/professional association statements and/or guidelines on delineation of hospital medical staff and clinical privileges?

In the **new** *Statements on Delineation of Hospital Privileges*.

Published by the American Medical Association (AMA) in November 1991, this up-to-date reference conveniently compiles 27 medical society/professional association statements and/or guidelines on delineation of hospital medical staff and clinical privileges into a single volume. It's an essential source of infor-

mation for hospital medical staffs and administrators, credentials review committees, and medical societies.

Order now. Each 384-page volume costs only \$14 for AMA members and \$18 for nonmembers. Call 800 621-8335 and request item OP031191 or complete and return the attached Order Form.

Clip here

Yes! Send me *Statements on Delineation of Hospital Privileges*, (OP031191), an essential 384-page, soft-bound book listing medical society/professional association statements and/or guidelines on delineation of hospital medical staff and clinical privileges.

Name (Please Print)

Title Organization

Address

City State Zip

Daytime phone number

AMA membership number (Required for discount)

Enclosed is my check payable to: American Medical Association.

Please charge my Visa American Express
MasterCard Optima

Account number Expiration date

Cardholder's signature

Overnight Delivery Available!

Copies @ \$14 each (AMA member) \$
Copies @ \$18 each (Nonmember) \$
Subtotal \$
Sales tax (see chart below.) \$
Please add \$3.50 shipping and handling for order totalling less than \$35.00 \$
For overnight delivery, please add \$15.00 \$
Total \$

Tax Exempt Organizations — please enclose a copy of your certificate.

To order by phone, call 800 621-8335. (Visa, American Express, MasterCard, Optima)

Send this order form to: American Medical Association, Order Dept., OP031191, PO Box 109050, Chicago, IL 60610

Sales Tax Chart (May vary by county)

AZ 6.7%	IA 4%	ND 6.5%	TN 7.75%
AR 6%	ID 5%	NE 6.5%	WA 8.1%
CA 7.28%	IL 8%	NV 6%	WI 5.5%
CT 8%	KS 6.25%	NY 8.25%	WV 6%
DC 6%	MN 6.6%	OH 7%	
GA 6%	NC 6%	SC 5%	

American Medical Association
Physicians dedicated to the health of America



High blood pressure focus of Indianapolis meeting

Indianapolis will be the host city for the Great Lakes Regional Conference on High Blood Pressure May 6, 7 and 8. The Indiana Government Center South will be the site of the meeting.

Issues to be addressed include kids and cholesterol, women and heart disease and media impact on behavior change. Sponsors include the Indiana State Department of Health, the Marion County Health Department and the Indiana University School of Medicine.

For registration information, call (317) 541-2097.

Free cancer screenings available to uninsured

St. Vincent Hospital in Indianapolis is offering free comprehensive cancer screenings to people age 50 and older who do not have health insurance.

The screenings are held each Thursday at Hometowne House, 2427 N. Central Ave., in Indianapolis. Screening tests include a mammogram, urinalysis, stool tests for blood, Pap smear and a sigmoidoscopy. Scott Pittman, M.D., provides medical direction for the program.

Appointments may be made by calling (317) 925-1142.

Grant to further Alzheimer's research at IUMC

The Indiana University Medical Center was awarded a five-year, \$2.5 million grant that will further Alzheimer's disease research, treatment and education efforts. The National Institute on Aging, a part of the National Institutes of Health, awarded the grant.

The grant provides funds for

additional staff and administrative resources for basic science research, the diagnosis and treatment of patients and the education of health care professionals and patient families.

Rural Health Association plans national conference

The National Rural Health Association (NRHA) will hold its 15th annual national conference, "Rural Health: Caring for the Country," May 6 to 9 at the Hyatt Regency Crystal City Hotel in Washington, D.C.

The conference is designed to present practical clinical sessions of interest to rural health providers and report results of research applicable to rural health service administrators and providers.

For registration information, call the NRHA, (816) 756-3140.

AMA publications offer help in converting to RBRVS

The American Medical Association has developed several publications and services designed to assist physicians in converting to the resource-based relative value scale (RBRVS) method of Medicare payment.

CPT 1992 provides a list of the AMA's 1992 Current Procedural Terminology (CPT) codes. CPT minibooks provide specific information for specialty areas, including radiology, pathology and laboratory medicine; gynecology, obstetrics and urology; neurological and orthopaedic surgery; dermatology and reconstructive surgery; general surgery, head and neck surgery; oral and maxillofacial surgery, ophthalmology and otorhinolaryngology; and several other specialties. The book is also available on magnetic tape in

short and long procedure description versions.

Medicare Physician Payment Reform: The Physicians' Guide provides the most recent information on RBRVS and explains its background and history.

Estimated Changes in Payments to Physicians aids physicians in estimating the impact of the RBRVS on their practices. The book includes estimates by specialty and location.

The above publications may be ordered by calling the AMA, 1-800-621-8335.

The Physicians Guide to Medicare, a subscription service developed in conjunction with Commerce Clearing House (CCH), includes information on payment schedules, appeals and claims submission. A semi-monthly newsletter with information on Medicare policy and other changes is included. Subscribers also will receive update pages to replace outdated information. To order call CCH, 1-800-248-3248.

Locums tenens service available from AMA

The American Medical Association (AMA) offers a service for physicians looking for short-term positions and for practices recruiting temporary replacements. The AMA's Locum Tenens Service provides recruiters and physicians with exposure through listing the positions in AMA's *Opportunity Placement Register* and through presenting abbreviated curricula vitae of physicians in AMA's *Physician Placement Register*.

For more information, contact Physicians Career Resource, AMA, P.O. Box 10012, Chicago, IL 60610, 1-800-955-3565. □

■classifieds

GENERAL INTERNISTS, full- or part-time, needed for the Department of Veterans Affairs Adam Benjamin Jr. Outpatient Clinic in Crown Point, Ind. Immediate and July 1992 openings available. This satellite clinic of VA Lakeside Medical Center in Chicago, Ill., offers Northwestern University Medical School faculty appointments to qualified persons, regular hours, no night call, challenging patients, on-site specialty services, a state-of-the-art facility, well-trained colleagues and a competitive salary. Qualifications include board eligibility/certification in internal medicine and U.S. citizenship or permanent alien status. We are an affirmative action/equal opportunity employer. Qualified women and minority candidates are encouraged to apply. Send curriculum vitae to James J. Holloway, M.D., ACOS for Ambulatory Care (11C), VA Lakeside Medical Center, 333 E. Huron St., Chicago, IL 60611.

CHIEF MEDICAL OFFICER for Department of Veterans Affairs Adam Benjamin Jr. Outpatient Clinic in Crown Point, Ind. Immediate opening for qualified physician to manage satellite clinic of a university-affiliated, Chicago-based tertiary care VA medical center. Opportunity offers Northwestern University Medical School faculty appointment to qualified individual, regular hours, a state-of-the-art facility, on-site specialty services and a competitive salary. Position includes managerial duties, clinical practice and teaching. Research opportunities available. Qualifications include board eligibility/certification in a recognized medical specialty and U.S. citizenship or permanent alien status. Internist with previous management experience preferred. We are an affirmative action/equal opportunity employer. Qualified women and minority candidates are encouraged to apply. Send curriculum vitae to Irwin Singer, M.D., Chief of Staff (11), VA Lakeside Medical Center, 333 E. Huron St., Chicago, IL 60611.

VACATION/TEMPORARY COVERAGE: BC/Anesthesiologist and CRNA desire to work locums. Call 1-800-241-7828.

HEMATOLOGY-ONCOLOGY: Private practice in southwest Indiana looking for associate leading to partnership. Extensive referral listings and excellent health care facilities. Respond to Tri-State Hematology Oncology, P.O. Box 5069, Evansville, IN 47716-5069.

WANTED: Physician to help family physician who wants to spend four to five months in Florida and work two to three days while in Lebanon, Ind. Free rent offered in my office next to Witham Hospital. Contact Jack L. Lenox, M.D., 1202 N. Lebanon St., Lebanon, IN 46052, (317) 482-5970.

EMERGENCY MEDICINE – Busy 375-bed community hospital. Double staffing. Superior prehospital system and excellent subspecialty coverage. Very competitive hourly rate with CME allowance. Contact Douglas Eberle, St. Elizabeth Hospital Medical Center, P.O. Box 7501, Lafayette, IN 47903.

ARE YOU SEEKING A POSITION in neonatology, orthopaedics, dermatology, allergy, radiology, oncology, neurosurgery or rheumatology? We have positions available in Ohio, Missouri, Wisconsin and Nebraska. Attractive guarantees and benefit packages. Single or multi-specialty groups. To discuss your practice preferences and these opportunities, please call our toll-free number, 1-800-243-4353, or send your CV to STRELCHICK & ASSOCIATES, INC., 10624 N. Port Washington Road, Mequon, WI 53092.

FAMILY PRACTICE, OB-GYN, INTERNAL MEDICINE AND URGENT CARE positions are available in a variety of settings from central Michigan, through Illinois, Wisconsin and Nebraska to the rolling plains of Kansas. Single or multi-specialty groups, faculty or solo with gener-

ous call coverage. Attractive guarantees and benefits. For more information, please contact our toll-free number, 1-800-243-4353, or send your CV to STRELCHICK & ASSOCIATES, INC., 10624 N. Port Washington Road, Mequon, WI 53092.

INDIANA – Superlative family practice opportunities available in a beautiful, family-oriented community in southern Indiana. The associate and partnership positions each offer an extraordinary financial package. OB is an optional consideration. Affiliated with a progressive 107-bed hospital. This economically secure and flourishing community is conveniently located 30 miles north of Louisville, Ky., and 80 miles south of Indianapolis. For further information, send CV to Andrew Johns, Physician Services of America, Suite 250, 2000 Warrington Way, Louisville, KY 40222, or call 1-800-626-1857, ext. 237.

ORTHOPAEDIC SURGEON – Immediate need for BE/BC orthopaedic surgeon in east central Indiana community of 20,000. This opportunity, in an ever-increasing sports-oriented community, is with multi-specialty clinic that has its own lab and x-ray and is skillfully managed for low overhead. The 107-bed hospital is state-of-the-art with a quality staff. Guarantee, productivity and benefits. For information, call 1-800-323-9567.

RADIOLOGY – Seven-person group is seeking an eighth radiologist with special interest in cross-sectional imaging. The Department of Radiology is expanding, is well-staffed and has all new and modern equipment. The initial salary is competitive, with a guaranteed bonus. The all-inclusive benefits are generous, with partnership potential. The excellent practice opportunity offers suburban living at its best and is located 45 minutes from downtown Chicago. For further information, please contact Peter E. Doris, M.D., Chairman, or

Antigoni Kencos, M.D., Vice Chairman, Department of Radiology, St. Anthony Medical Center, Crown Point, IN 46307, (219) 757-6320.

EMERGENCY MEDICINE – Full- and part-time positions available for Indiana hospital emergency departments. Offering flexible scheduling, competitive wages and malpractice insurance. Contact Stephen R. Myron, M.D., 430 W. Votaw, Portland, IN 47371, 1-800-858-6735 or (219) 726-6327.

OSHKOSH, WISCONSIN – Single-specialty groups are recruiting in pediatrics, ob/gyn, cardiology, pathology and orthopaedic surgery. Oshkosh is an attractive community of 55,000 people, located on the shores of Lake Winnebago and in the heart of Wisconsin's beautiful Fox River Valley. Competitive financial packages. Contact Christopher Kashnig, Physician Recruiter, Mercy Medical Center, 631 Hazel St., Oshkosh, WI 54902, or call 1-800-242-5650, ext. 2430, or (414) 236-2430.

FAMILY PRACTITIONERS/INTERNISTS – MetroHealth, an affiliate of Methodist Hospital of Indiana, Inc., is seeking board-certified/eligible family practitioners and internists. Share the advantages of joining an established prepaid multi-specialty physician group offering an ideal blend of practice and lifestyle, paid professional liability and competitive compensation and fringe benefit packages. Our practice is located in Indianapolis, a thriving Midwest community offering a number of cultural, educational and recreational activities. For confidential consideration, submit curriculum vitae to MetroHealth Physician Recruitment, P.O. Box 1367, Indianapolis, IN 46206.

INTERNISTS, PEDIATRICIANS, FAMILY PRACTICE PHYSICIANS – Outstanding practice opportunity in one of the most attractive locations in the Midwest – Goshen, Ind. Located

in north central Indiana, Goshen is bordered by hundreds of sparkling lakes, great for sailing or skiing enthusiasts; numerous wooded parks; and unspoiled rolling countryside. Its proximity to South Bend, home of the University of Notre Dame, provides a wide spectrum of spectator sports, quality concerts, theater and fine dining. Goshen College embodies the community's commitment to quality education that makes its primary and secondary schools among the best in the state. A strong economy (Goshen's manufacturing employment growth was ranked 16th in the nation by American Demographics) helps ensure a quality lifestyle. A receptive medical staff supports this recruitment and will provide excellent call and coverage. For more information, call or write Rick Addis, Goshen General Hospital, P.O. Box 139, Goshen, IN 46526; hospital, 1-800-258-4321, or home, (219) 533-8311.

PRO-LIFE OBSTETRICS AND GYNECOLOGY group seeks a third associate for a rapidly expanding practice. Retirement of three OB/GYNs within 18 months has created a dramatic need for expansion in this specialty. Take advantage of the recreational possibilities of nearby Michigan while enjoying the professional advantages of practice in Indiana. Call or write Jeffrey L. Cain, M.D., West Side Obstetrics & Gynecology, P.C., Elkhart, IN 46514, (219) 293-6999.

MULTIPLE AND VARIED physician practice opportunities currently exist both within and outside Indiana. Call Patti Quiring at work, (317) 841-7575, or at home, (317) 823-4746. Patti is a physician recruiter for Quiring Associates, an executive search firm headquartered in Indianapolis.

GENERAL INTERNIST – BC/BE. To join a busy five-man practice with special interest in hospital intensive care, plus consultative and primary

care practice in the Indianapolis area. Will offer partnership. Reply to Box 19616, Indianapolis, IN 46219.

POSITION AVAILABLE with thriving three-clinic urgency care corporation. Practice heavily emphasizing industrial, sports medicine and wellness programs. Regular work week, no call. Assistant medical director available. Salary and benefits in six figures. Contact Dr. Dean Elzey, (219) 489-2772.

EMERGENCY MEDICINE – Terre Haute, Ind. Local multi-hospital group seeking full-time career-oriented emergency physician for position in small- and medium-volume community hospitals. Flexible scheduling, very competitive compensation package, partnerships available. Send CV or contact William R. Grannen, Priority Health Care, P.C., 7179 Lamplite Ct., Cincinnati, OH 45244, (513) 231-0922.

EMERGENCY PHYSICIANS WANTED – For Fayette Memorial Hospital in Connersville, Ind. Will consider all physicians with emergency medicine experience. 15,000 visits/year. Fee-for-service group does its own billing. Hourly compensation based on training, experience and qualifications. Excellent fringe benefit package includes, life, health, disability and malpractice insurance plus CME allowance, ACEP and ISMA dues, pension plan and potential bonus. Contact Michael D. Bishop, M.D., FACEP, Emergency Care Physicians, 640 S. Walker St., Suite A, Bloomington, IN 47403, (812) 333-2731.

CENTRAL INDIANA – Physician-owned emergency group accepting applications for full-time, career-oriented emergency physicians. Flexible work schedules and excellent benefit package. Part-time and directorship positions also available. Send CV or contact Midwest Medical Management, Inc., 3645 S. East St., Indianapolis, IN 46227-1240, (317) 783-7474. □

YOCON[®]

YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it, however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral alpha-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

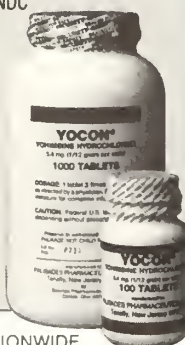
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

**PALISADES
PHARMACEUTICALS, INC.**
219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

Advertising index

AdminaStar Electronic Services	109
American Medical Association	180
Arnett Clinic	135
Auto Buyers Network	140
Caylor-Nickel Clinic	105
Central Pharmaceuticals	145
Ford	145
Lilly, Eli & Co.	110, 111
Lincoln National Life	Cover
Medical Protective	119
Midwest Cardiovascular Research	149
Palisades Pharmaceuticals	184
Physicians' Directory	150
Physicians Insurance Co. of Indiana	Cover
Records Management Services	111
Roche Laboratories	103, 117, 118
G.D. Searle and Company	Cover
Spectrum Emergency Care	108
St. Luke's Hospital	102
University Microfilms	140
University Place	139
U.S. Air Force	116

In accepting advertising for publication, INDIANA MEDICINE has exercised reasonable precaution to ensure that only reputable, factual advertisements are included. However, we do not have facilities to make comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services, medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertisers only. Neither sanction nor endorsement of such is warranted, stated or implied by the association.

Are you moving?

If so, please send change of address to the Indiana State Medical Association, Membership Department, 322 Canal Walk, Indianapolis, IN 46202-3252, at least six weeks before you move.

Name: _____
Address: _____
City: _____
State: _____ Zip: _____ County: _____
Office phone: _____ Home phone: _____

IMPORTANT - Attach mailing label from your last copy of INDIANA MEDICINE here:

ISMA Health/Dental Insurance

Benefits available to members of the Indiana State Medical Association and their employees through expanded ISMA group sponsored health insurance.

MEDICAL PLAN A

- 365 Days of Inpatient Hospital Care
- 100% payment semi-private or hospital ward room
- 365 Days In-Hospital Medical Care
- 100% reasonable and customary allowances for surgery, maternity, general anesthesia, medical visits, radiation therapy, and other eligible inpatient hospital charges
- Unlimited Major Medical Benefits (\$100 deductible)

MEDICAL PLAN B

- Comprehensive Major Medical protection
- \$250 calendar year deductible, \$500 per family
- Stop-Loss Limit \$5,000 per person, \$10,000 per family
- PCS Card
- Includes cost-containment features
- Unlimited Maximum Benefits

MEDICAL PLAN C

- Comprehensive Major Medical protection
- \$500 calendar year deductible, \$1,000 per family
- Stop-Loss Limit \$5,000 per person, \$10,000 per family
- Unlimited Maximum Benefits

MEDICAL PLAN D

- Economical Comprehensive Major Medical protection
- \$1,000 calendar year deductible, \$2,000 per family
- Stop-Loss Limit \$5,000 per person, \$10,000 per family
- Unlimited Maximum Benefits

MEDICAL PLAN E

- Low cost Comprehensive Major Medical protection
- \$2,000 calendar year deductible, \$6,000 per family
- Stop-Loss Limit \$10,000 per person, \$30,000 per family
- Unlimited Maximum Benefits

DENTAL PLAN

- Reasonable and customary allowances for necessary care and treatment for dental health - \$50 calendar year deductible, \$100 per family
- \$1,500 maximum dental benefit per person in a calendar year paid at 80%, additional major dental paid at 50%
- \$1,000 Orthodontia Benefits paid at 50% of reasonable and customary charges

MEDICAL REIMBURSEMENT PLAN

- Tax deductible to the professional corporation

The Lincoln National Life Insurance Company is most pleased to be underwriting the Group Medical and Dental Program for the Indiana State Medical Association. Your benefit programs have been designed to provide the highest quality coverage and service at the lowest possible cost. A special claim paying unit has been established in our Fort Wayne Regional Claims Office to handle only the ISMA program. Should you have questions or problems, you may speak directly to your claim processor at 1-800-338-0363. We look forward to serving you and encourage your review of the program and services being provided.

SUPPLEMENTAL BENEFITS FOR ORGAN OR TISSUE TRANSPLANTS

- Included with all medical plans.
- Covered Transplant Procedures: This policy covers any of the following human to human organ or tissue transplants: bone marrow; heart; heart/lung; liver; cornea.
- Maximum Transplant Benefit: \$1,000,000 per lifetime per insured person for all transplant services.

For more information regarding these coverages contact:

Earl W. Williams
Professional Account Representative
11595 N. Meridian St., Suite 802
Carmel, Indiana 46032
(317) 573-6520
1-800-421-3020
(317) 573-6524 FAX

Tom Martens
Director, Health Insurance Administration
Indiana State Medical Association
322 Canal Walk
Indianapolis, Indiana 46202-3252
(317) 261-2060
1-800-969-7545 Indiana
(317) 261-2076 FAX

AFFILIATED PHYSICIANS SERVICES, INC.
ISMA Agency



The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control.

A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature).

Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk, therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia HR < 50/min (1.4%), AV block total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6277V

Address medical inquiries to
G.D. Searle & Co.
Medical & Scientific
Information Department
4901 Searle Parkway
Skokie, IL 60077

SEARLE

G.D. Searle & Co.
Box 5110, Chicago, IL 60680

A91CA6148T

When diet and exercise alone are not enough...



ONCE
DAILY **180mg**
Calan SR
verapamil HCl 180mg
SUSTAINED-RELEASE CAPLETS

A MILD START IN MILD HYPERTENSION

© 1991, C.D. Searle & Co.

INDIANA MEDICINE

The Journal of the Indiana State Medical Association

May/June 1992

Vol. 85, No. 3

MS
N.E. JOURN OF MED
10 SHATTUCK STREET
BOSTON
MA 02110

MS

EVANSVILLE CRASH

Medical teams praised for rescue efforts





**Choosing
PICI is
an open
and
shut case**

With PICI's track record for success in defending claims, it would be easy for us to rest on our laurels. But after all of our successes and words of gratitude from our physician policyholders, we still get defensive.

As a physician-owned company, dedicated to our insureds and their practices, we always defend against claims that have no merit. We do not settle suits to save money. In fact, we can not settle without your consent. Never have, never will.

When an insured's reputation is on the line, so is PICI's.

We're proud to say we're defensive. It's a way of doing business that has yielded positive results, to the relief and satisfaction of our policyholders.



**PHYSICIANS INSURANCE
COMPANY OF INDIANA**

5425 Woodfield Crossing Blvd., Suite 300
Indianapolis, IN 46240
317/469-4100 800/284-7424

Indiana
State
Medical
Association



"Together, We Make The Difference"

MAY 22 1992

INDIANA MEDICINE

The Journal of the Indiana State Medical Association

May/June 1992

Vol. 85, No. 3

features

Health commissioner concerned about access to care 198
INDIANA MEDICINE interviews John Christopher Bailey, M.D., commissioner of the Indiana State Department of Health, on public health issues facing Indiana.

Indiana chosen for pilot project in risk management 206
Indiana is looking for 250 primary care physicians to participate in a program to reduce their liability risks.

Medical teams praised for rescue efforts 212
Emergency planners and medical officials praised Evansville's disaster response after a Kentucky Air National Guard military transport plane crashed into a hotel and restaurant.

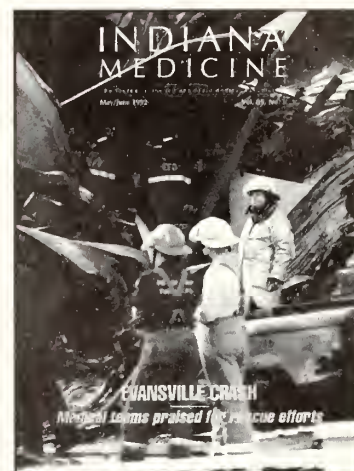
Ethical issues in withholding and withdrawing life-sustaining treatment 218
Four general principles should be considered when making decisions about limiting life-sustaining treatment.

Valuing a practice for purchase or sale 222
Valuing a practice is an art, not a science, and differences in patient mix, cost of operations, staffing, equipment, facilities and location will affect the valuation.

ISMA successful during 1992 legislative session 228
More than 200 of the legislature's 902 bills were monitored by the ISMA legislative staff.

scientific contribution

Delayed posttraumatic diaphragmatic hernia:
Case report and literature review 230

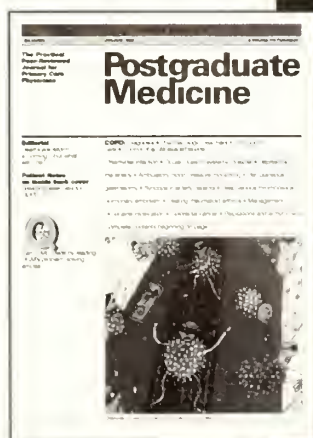


Cover story on page 212.
Photo by Richard Hicks of The Evansville Courier. Cover design by Diane Alfonso, Indianapolis.

departments

stethoscope 188
editorials 190, 192
letters to the editor 196
drug names 227
auxiliary report 234
cme calendar 257
what's new 258
obituaries 260
people 262
news briefs 265
classifieds 266
isma leadership 269

US THEM



**Postgraduate
Medicine**

**WHEN YOU NEED
TIME ON YOUR
SIDE, THE CHOICE
IS CLEAR.**

**NO CLINICAL
CLUTTER—
PGM ARTICLES
ARE CLEAR,
CONCISE, WELL
ILLUSTRATED,
AND PRACTICAL.**

INDIANA MEDICINE

Devoted to the interests of the medical profession and public health in Indiana since 1908.

MANAGING EDITOR

Tina Sims

EDITORIAL ASSISTANT

Toni Settle

BUSINESS MANAGER

Richard R. King

CIRCULATION

Rosanna Iler

EDITORIAL BOARD CHAIRMAN

George T. Lukemeyer, M.D.

EDITORIAL BOARD

Thomas J. Conway, M.D.

Robert C. Ziss, M.D.

(Terms expire Dec. 31, 1992)

James R. Buechler, M.D.

James W. Edmondson, M.D.

Robert L. Forste Jr., M.D.

George C. Manning, M.D.

Bruce F. Waller, M.D.

(Terms expire Dec. 31, 1993)

Franklin Roesner

Paul Forman

(Medical students)

CONSULTING EDITORS

Steven C. Beering, M.D.

Charles A. Bonsett, M.D.

Walter J. Daly, M.D.

Alvin J. Haley, M.D.

Rodney A. Mannion, M.D.

Alan T. Marty, M.D.

EDITOR EMERITUS

Frank B. Ramsey, M.D.

INDIANA MEDICINE (ISSN 0746-8288) is published six times a year (in January, March, May, July, September and November) by the Indiana State Medical Association. Second-class postage paid at Indianapolis, Ind., and additional mailing offices.

Address correspondence relating to editorial material, advertising or subscriptions to: INDIANA MEDICINE, 322 Canal Walk, Indianapolis, IN 46202-3252. Phone (317) 261-2060 or 1-800-257-ISMA.

Annual subscription rates for nonmembers: \$15 domestic, \$17 Canada, \$18 foreign. Medical library rates: \$14 domestic, \$15 Canada, \$16 foreign. Full-time Indiana medical students: \$7. Single copies not available. Subscriptions are renewable annually.

POSTMASTER: Send address changes to INDIANA MEDICINE, Indiana State Medical Association, c/o Membership Department, 322 Canal Walk, Indianapolis, IN 46202-3252.

Views expressed do not reflect the opinions of the editors. No copyright is claimed, unless specifically indicated. Copyright rests solely with authors, who are responsible for statements in their articles. Scientific and editorial contributions are accepted for exclusive publication, subject to editorial requirements. Instructions for authors available on request.

All issues since 1967 are available on microfilm from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, MI 48106. Indexed in *Index Medicus* and *Hospital Literature Index*.

Advertising rates and data available upon request. INDIANA MEDICINE reserves the right to accept or reject advertising.

ELECTRONIC

CLAIMS

S U B M I S S I O N

...

*Erica*SM

AdminaStar
Electronic Services
a division of AdminaStar, Inc.

THE ERICA FAMILY OF PRODUCTS
CONNECTS INDIANA **HOSPITALS**
AND **PHYSICIANS** WITH SYSTEMS
AND PEOPLE WHO CAN HELP
MANAGE YOUR OFFICE'S MOST
IMPORTANT OPERATIONS-CLAIMS,
INQUIRY AND REMITTANCE.
BETTER. FASTER. AND MORE
EFFICIENTLY.

OUR NEW CLAIMS SOFTWARE,
FASTMC, LETS YOU BILL
HCFA 1500 AND UB 82 CLAIMS
ON ALMOST ANY COMPUTER
PLATFORM.

**CALL TODAY FOR A
FREE DEMONSTRATION**

**THE PEOPLE WHO PRACTICALLY
INVENTED ELECTRONIC CLAIMS**

1.800.
437.4221

Law requires distribution of vaccine information pamphlets

Physicians who administer immunizations to children are now required to provide vaccine information pamphlets to the child's parent or guardian. The pamphlets are available to ISMA members through CORPrint of Indianapolis. Three pamphlets, "Diphtheria, Tetanus and Pertussis," "Measles, Mumps and Rubella" and "Polio," may be ordered in increments of 50, at a cost of \$12 per hundred, plus shipping and handling. To order, call CORPrint at (317) 255-2178. Orders will be shipped COD within seven working days from receipt of order.

The requirement concerning the distribution of the vaccine information pamphlets, developed by the Centers for Disease Control, is part of the national Childhood Vaccine Injury Act. The Indiana State Department of Health has provided camera-ready copies of the pamphlets to physicians. The law says physicians are responsible for printing the information, using any material that meets the requirements of the law.

Sponsors needed for bills equalizing Medicare payments

ISMA physicians are being asked to urge Indiana senators and representatives in Congress to become co-sponsors of two bills repealing limits on Medicare payments to "new physicians." Sen. John McCain, R-Ariz., introduced S 2362 to repeal the provisions of current law that mandate Medicare payment reductions for physicians in their first four years of practice, and Rep. Edolphus Towns, D-N.Y., introduced HR 4507 that is identical to the Senate bill.

Congress intended for the "new physician" reductions to apply to individuals in their first four years of practice. However, physicians who have been in practice for several years, such as former military doctors or physicians in group practices who have not individually billed for services provided to a Medicare beneficiary, also are subjected to the reductions.

For more information, call the ISMA Department of Government Relations, (317) 261-2060 or 1-800-257-4762.

ISMA membership directories to be distributed this month

ISMA members will receive a free copy of the 1992-93 ISMA membership directory sometime this month. The directory lists ISMA members alphabetically and by county, county society staff, Indiana hospitals and membership statistics by county and specialty. Those who wish to order additional directories should complete and return the order form in the back of the directory, along with payment, to ISMA, attn: Directory Orders, 322 Canal Walk, Indianapolis, IN 46202-3252. Additional directories are \$20 each for ISMA members and \$40 each for non-members. Directory orders will not be accepted by phone. □

Your Rx for Valium

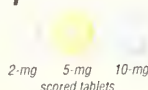
(brand of diazepam/Roche)



may be open to
seventeen
interpretations...

unless you settle the issue by signing
on the "Dispense as Written" line.

VALIUM[®]
brand of
diazepam/Roche[®]



The final choice should really be yours

The cut out "V" design is a registered trademark of Roche Products Inc.
Copyright © 1991 by Roche Products Inc. All rights reserved.

ROCHE

Roche Products

Roche Products Inc.
Manati, Puerto Rico 00701

*According to the Orange Book, 10th ed, US Department of Health
and Human Services, 1990, diazepam tablets may be available from as many
as 17 companies. Tablets shown represent 5 mg diazepam tablets.

Practice parameters: How should we view them?

John F. Williams Jr., M.D.
Indianapolis

Practice parameters have been defined as strategies for patient management designed to assist physicians in clinical decision making. Parameters include standards, guidelines, practice policies and practice options. Others, however, use practice parameters and guidelines interchangeably – as I will – and the major thrust in the development of management strategies today is in the development of guidelines. A few professional societies have been involved in guideline development for many years. Now, there is an explosion of activity in this area. Most major professional societies are developing guidelines and have been joined by several academic medical centers and governmental and non-governmental organizations.

Guidelines were developed initially as educational tools to assist physicians in providing optimal patient management. Yet, we hear more and more of their use to control health care costs, in utilization review and even in liability issues. Their use for the latter reasons should not be condemned categorically because, in some cases, they may be helpful. For example, guidelines used in utilization review can enhance physician education and, when used appropriately for reimbursement, can be an additional stimulus for improved practice. Guidelines should not be viewed primarily as a means to control costs, however. If diagnostic tests or therapies are being ordered inappropriately as has been charged, cost might be reduced by guidelines. Conversely, one may find areas in which guidelines could increase costs.

The effect of guidelines on

malpractice issues remains an open question, but is being tested. Legislation has been enacted in Maine that would protect physicians using guidelines developed by four specialty societies from malpractice claims.

Are there potential downsides to the use of guidelines? Most frequent concerns relate to “cookbook” medicine, liability issues, if guidelines are effective, or whether they will be used primarily for reimbursement purposes. Also, with the myriad of guidelines now appearing, how does one determine a “good” guideline?

When properly developed and used, guidelines should not promote “cookbook” medicine. Are not textbooks guidelines? Physicians are aware of the need to individualize patient management strategies, and guidelines should be just that – guidelines. One who deviates from an accepted guideline, however, should be prepared to defend that position.

Physicians fear that failure to follow guidelines could lead to adverse malpractice actions. There are cases in which this has been so. Hopefully, the Maine experience will demonstrate how guidelines can be used to protect against such actions.

Guidelines can be effective. After reviewing malpractice claims, the American Society of Anesthesiologists developed a practice parameter involving the monitoring of patients' oxygenation under anesthesia. This study resulted in a marked reduction in adverse events and subsequently in malpractice premiums. Several years ago, it was charged that many pacemakers were being implanted unnecessarily. Subsequently, the American College of Cardiology and American Heart Association jointly issued guidelines on the indications for pace-

maker implantation, and pacemaker implants dropped approximately 25%.

Unfortunately, some guidelines clearly are unusable by physicians and usable only by regulators and reimbursers. What then is a “good” guideline? The AMA, in conjunction with 13 specialty societies, has formed the AMA/Specialty Society Practice Parameters Partnership to guide and coordinate the activity of organized medicine in the development, evaluation, implementation and application of practice parameters. They have developed *Attributes To Guide The Development Of Practice Parameters* and a mechanism to determine conformance to these *Attributes*. The *Attributes* state that physicians must be involved in the development of guidelines; participants must possess scientific and clinical expertise in the content area; the methodology and evidence used must be described. Also, the parameter must be comprehensive and specific, reviewed at least every three years and widely disseminated. Conformance to these *Attributes* should help ensure the validity of the parameters.

Guidelines will increasingly affect physicians' practices, and the government will be increasingly involved as evidenced by the congressional mandate to the Agency for Health Care Policy and Research to develop such guidelines. Physicians' organizations should insist that physicians play the major role in guidelines development and that the principle purpose of the guidelines is to improve the quality of care. If so, guidelines will be helpful. □

The author is director of Wishard Memorial Hospital in Indianapolis.



To Plan The Most Successful Conference Possible, You Really Should Check All Your Options.

The University Place Conference Center & Hotel offers all the options you should expect to make your conference a success. And, probably a few things you'd never expect. So, if you'd like a free information packet on the features listed, call **800-627-2700**. Because once you've checked us out, you won't even consider any other location as an option.



University Place

Conference Center & Hotel

On the Campus of Indiana University • Purdue University
I N D I A N A P O L I S

800-627-2700

(In Indiana 317-274-3196)

Features	<i>University Place</i>
278-room AAA 4-Diamond hotel	✓
Resources of two major universities	✓
338-seat auditorium with sloped seating	✓
Unmatched A/V capabilities	✓
Award-winning restaurants	✓
385-car underground garage	✓
Full-time A/V staff	✓
Turnkey Conference Planning Service	✓
Skywalk to Olympic-class sports facilities	✓
Thirty soundproof meeting rooms	✓
Two tiered meeting rooms	✓
Videoconferencing	✓
Computerized audience response system	✓
Continuous refreshment service	✓

Physicians encouraged to participate in PA/QI program

George T. Lukemeyer, M.D.
Chairman, Editorial Board
INDIANA MEDICINE

Editor's note: See related article on page 206.

Are there non-clinical ways of managing your risk of being sued for malpractice? The AMA thinks so, and has developed a pilot project to test its theory. The Practice Assessment/Quality Improvement Program (PA/QI) is outlined in this issue of *INDIANA MEDICINE*. Indiana was one of eight states selected for a PA/QI pilot project that is scheduled to begin recruiting physician participants this month. Its sponsors are the ISMA and Physicians Insurance Company of Indiana (PICI). The AMA selected Indiana for several reasons, among them, ISMA's and PICI's close working relationship; Indiana's landmark Indiana Compensation Act for Patients (INCAP) and the fact the ISMA is currently conducting a public and media education campaign on INCAP.

There are several reasons why you should examine PA/QI and consider participating. If you objectively review your medical

office management practices, chances are you will find you are continuing to run things exactly as you always have. This "if it isn't broken, don't fix it" attitude doesn't hold up in an era of continued changes in medicine.

Many initiatives are bearing down on physicians today, often at the expense of quality. PA/QI was designed by physicians to improve the quality of patient care, minimize patient injury and/or reduce the risk of malpractice litigation. PA/QI gathers and analyzes data on current office risk management practices. Physicians can then identify and make decisions about appropriate changes in their risk management activities. They can see how they rank with other physicians in their specialty in Indiana or nationally. Over time, the AMA, while maintaining the confidentiality of the data, will be able to determine the utility of risk management practices in improving patient care and preventing liability claims.

Aside from the positive impact on patient care, there are some pragmatic reasons for you to take advantage of PA/QI. Malpractice costs are still the fastest growing component of health care. Both doctors and their pa-

tients benefit from the Indiana Compensation Act for Patients, and indeed Indiana is the envy of almost every other state in terms of our malpractice law. The Indiana Compensation Act for Patients has reduced malpractice insurance premiums and maintained access to medical care, but if risk management practices can alleviate malpractice costs even more, physicians in Indiana ought to integrate them into their non-clinical office procedures.

One of the suggestions from the Solutions Subcommittee of the State Health Policy Commission was mandatory risk management for physicians. No one knows if or when it will come to pass. Certainly an ISMA and PICI program on behalf of all physicians seems much more palatable than yet another mandated program. Indeed, few recent issues have provided an opportunity to be proactive. This one does.

The AMA was wise to develop PA/QI through its AMA/Specialty Society Liability Project (AMA/SSLP), and the ISMA and PICI boards are to be commended for having the foresight to apply to be a pilot site. □

The ACCUPRILTM Single-Agent Commitment

Parke-Davis is confident that for many of your hypertensive patients ACCUPRIL will achieve the decrease in blood pressure you expect.

If, in your medical judgment, your patient requires a diuretic in addition to ACCUPRIL at any time during ACCUPRIL therapy, Parke-Davis will refund your patient's cost of the diuretic.*†



New!
ONCE-A-DAY ‡
ACCUPRIL[®] 
quinapril HCl tablets 10, 20, 40 mg

* See DOSAGE AND ADMINISTRATION section of prescribing information.

† If, after an adequate trial of ACCUPRIL alone, based on your medical judgment as the prescribing physician, you determine that your patient requires the addition of a diuretic, Parke-Davis will refund to the patient his/her cost for the diuretic prescription less any amount reimbursed or paid for by an HMO, insurance company, or any other plan or program.

For more details, ask your Parke-Davis Representative or call 1-800-955-3077.

‡ In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

ACCUPRIL is available in 10, 20, and 40 mg tablets. Usual initial starting dosage is 10 mg once daily.

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Please see brief summary of prescribing information on following page.



Accupril® (Quinapril Hydrochloride Tablets)

Before prescribing, please see full prescribing information. A brief summary follows.

INDICATIONS AND USAGE

ACCUPRIL is indicated for the treatment of hypertension. It may be used alone or in combination with thiazide diuretics. In using ACCUPRIL, consideration should be given to the fact that another angiotensin-converting enzyme (ACE) inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen vascular disease. Available data are insufficient to show that ACCUPRIL does not have a similar risk (see WARNINGS).

CONTRAINDICATIONS

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

WARNINGS

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with ACE inhibitors and has been seen in 0.1% of patients receiving ACCUPRIL. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with ACCUPRIL should be discontinued immediately, the patient treated in accordance with accepted medical care, and carefully observed until the swelling disappears. In instances where swelling is confined to the face and lips, the condition generally resolves without treatment, antihistamines may be useful in relieving symptoms.

Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, emergency therapy including, but not limited to, subcutaneous epinephrine solution 1:1000 (0.3 to 0.5 mL) should be promptly administered (see ADVERSE REACTIONS).

Hypotension: Symptomatic hypotension was rarely seen in uncomplicated hypertensive patients treated with ACCUPRIL but, as with other ACE inhibitors, it is a possible consequence of therapy in salt/volume depleted patients, such as those previously treated with diuretics or dietary salt restriction or who are on dialysis (see PRECAUTIONS, DRUG INTERACTIONS, and ADVERSE REACTIONS). In controlled studies, syncope was observed in 0.4% of patients (N = 3203); this incidence was similar to that observed for captopril (1%) and enalapril (0.8%).

In patients with concomitant congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria or azotemia and, rarely, with acute renal failure and death. In such patients, ACCUPRIL therapy should be started at the recommended dose under close medical supervision. These patients should be followed closely for the first 2 weeks of treatment and whenever the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

If symptomatic hypotension occurs, the patient should be placed in the supine position and, if necessary, normal saline may be administered intravenously. A transient hypotensive response is not a contraindication to further doses, however, lower doses of ACCUPRIL or reduced concomitant diuretic therapy should be considered.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression rarely in patients with uncomplicated hypertension, but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease such as systemic lupus erythematosus or scleroderma. Agranulocytosis did occur during ACCUPRIL treatment in one patient with a history of neutropenia during previous captopril therapy. Available data from clinical trials of ACCUPRIL are insufficient to show that, in patients without prior reactions to other ACE inhibitors, ACCUPRIL does not cause agranulocytosis at similar rates. As with other ACE inhibitors, periodic monitoring of white blood cell counts in patients with collagen vascular disease and/or renal disease should be considered.

Fetal/Neonatal morbidity and mortality: ACE inhibitors, including ACCUPRIL, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and death. Oligohydramnios has also been reported, presumably based on decreased fetal renal function, oligohydramnios has been associated with fetal limb contractures, craniofacial deformities, hypoplastic lung development, and intrauterine growth retardation.

Prematurity and patent ductus arteriosus have been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure or to the mother's underlying disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.

A patient who becomes pregnant while taking ACE inhibitors, or who takes ACE inhibitors when already pregnant, should be apprised of the potential hazard to her fetus. If she continues to receive ACE inhibitors during the second or third trimester of pregnancy, frequent ultrasound examinations should be performed to look for oligohydramnios. When oligohydramnios is found, ACE inhibitors should generally be discontinued.

Infants with histories of in utero exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Hemodialysis and peritoneal dialysis have little effect on the elimination of quinapril and quinaprilat.

No fetotoxic or teratogenic effects were observed in rats at quinapril doses as high as 300 mg/kg/day (180 and 30 times the maximum daily human dose when based on mg/kg and mg/m², respectively), despite maternal toxicity at 150 mg/kg/day. Tested later in gestation and during lactation, reduced offspring body weight was seen at ~25 mg/kg/day, and changes in renal histology (nephropathy, tubular pelvic dilation, glomerulosclerosis) were observed both in dams and offspring treated with 150 mg/kg/day. Quinapril was not teratogenic in the rabbit, however, as noted with other ACE inhibitors, maternal toxicity and embryofetal loss were seen in some rabbits at quinapril doses as low as 0.5 mg/kg/day (one time the recommended human dose) and 1.0 mg/kg/day, respectively.

PRECAUTIONS

General

Impaired renal function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including ACCUPRIL, may be associated with oliguria and/or progressive azotemia and rarely acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine have been observed in some patients following ACE inhibitor therapy. These increases were almost always reversible upon discontinuation of the ACE inhibitor and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when ACCUPRIL has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of any diuretic and/or ACCUPRIL may be required.

Evaluation of hypertensive patients should always include assessment of renal function (see DOSAGE AND ADMINISTRATION).

Hyperkalemia and potassium-sparing diuretics: In clinical trials, hyperkalemia (serum potassium ≥ 5.8 mmol/L) occurred in approximately 2% of patients receiving ACCUPRIL. In most cases, elevated serum potassium levels were isolated values which resolved despite continued therapy. Less than 0.1% of patients discontinued therapy due to hyperkalemia. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with ACCUPRIL (see PRECAUTIONS, Drug Interactions).

Surgery/anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, ACCUPRIL will block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients

Angioedema: Angioedema, including laryngeal edema, can occur with treatment with ACE inhibitors, especially following the first dose. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to stop taking the drug until they have consulted with their physician (see WARNINGS).

Symptomatic hypotension: Patients should be cautioned that lightheadedness can occur, especially during the first few days of ACCUPRIL therapy, and that it should be reported to a physician. If actual syncope occurs, patients should be told to not take the drug until they have consulted with their physician (see WARNINGS).

All patients should be cautioned that inadequate fluid intake or excessive perspiration, diarrhea, or vomiting can lead to an excessive fall in blood pressure because of reduction in fluid volume, with the same consequences of lightheadedness and possible syncope.

Patients planning to undergo any surgery and/or anesthesia should be told to inform their physician that they are taking an ACE inhibitor.

Hyperkalemia: Patients should be told not to use potassium supplements or salt substitutes containing potassium without consulting their physician (see PRECAUTIONS).

Accupril® (Quinapril Hydrochloride Tablets)

Neutropenia: Patients should be told to report promptly any indication of infection (eg, sore throat, fever) which could be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with ACCUPRIL is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions

Concomitant diuretic therapy: As with other ACE inhibitors, patients on diuretics, especially those on recently instituted diuretic therapy, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with ACCUPRIL. The possibility of hypotensive effects with ACCUPRIL may be minimized by either discontinuing the diuretic or cautiously increasing salt intake prior to initiation of treatment with ACCUPRIL. If it is not possible to discontinue the diuretic, the starting dose of quinapril should be reduced (see DOSAGE AND ADMINISTRATION).

Agents increasing serum potassium: Quinapril can attenuate potassium loss caused by thiazide diuretics and increase serum potassium when used alone. If concomitant therapy of ACCUPRIL with potassium-sparing diuretics (eg, spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes is indicated, they should be used with caution along with appropriate monitoring of serum potassium (see PRECAUTIONS).

Tetracycline and other drugs that interact with magnesium: Simultaneous administration of tetracycline with ACCUPRIL reduced the absorption of tetracycline by approximately 28% to 37%, possibly due to the high magnesium content in ACCUPRIL tablets. This interaction should be considered if coprescribing ACCUPRIL and tetracycline or other drugs that interact with magnesium.

Lithium: Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be co-administered with caution, and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity.

Other agents: Drug interaction studies of ACCUPRIL with other agents showed:

- Multiple dose therapy with propranolol or cimetidine has no effect on the pharmacokinetics of single doses of ACCUPRIL.
- The anticoagulant effect of a single dose of warfarin (measured by prothrombin time) was not significantly changed by quinapril administration twice-daily.
- ACCUPRIL treatment did not affect the pharmacokinetics of digoxin.
- No pharmacokinetic interaction was observed when single doses of ACCUPRIL and hydrochlorothiazide were administered concomitantly.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Quinapril hydrochloride was not carcinogenic in mice or rats when given in doses up to 75 or 100 mg/kg/day (50 to 60 times the maximum human daily dose, respectively, on a mg/kg basis and 3.8 to 10 times the maximum human daily dose when based on a mg/m² basis) for 104 weeks. Female rats given the highest dose level had an increased incidence of mesenteric lymph node hemangiomas and skin/subcutaneous lipomas. Neither quinapril nor quinaprilat were mutagenic in the Ames bacterial assay with or without metabolic activation. Quinapril was also negative in the following genetic toxicology studies: *in vitro* mammalian cell point mutation, sister chromatid exchange in cultured mammalian cells, micronucleus test with mice, *in vitro* chromosome aberration with V79 chromated lung cells, and *in vivo* cytogenetic study with rat bone marrow. There were no adverse effects on fertility or reproduction in rats at doses up to 100 mg/kg/day (60 and 10 times the maximum daily human dose when based on mg/kg and mg/m², respectively).

Pregnancy

Pregnancy Category D: See WARNINGS, Fetal/Neonatal morbidity and mortality.

Nursing Mothers

It is not known if quinapril or its metabolites are secreted in human milk. Quinapril is secreted to a limited extent, however, in milk of lactating rats (5% or less of the plasma drug concentration was found in rat milk). Because many drugs are secreted in human milk, caution should be exercised when ACCUPRIL is given to a nursing mother.

Geriatric Use

Elderly patients exhibited increased area under the plasma concentration time curve (AUC) and peak levels for quinaprilat compared to values observed in younger patients, this appeared to

relate to decreased renal function rather than to age itself. In controlled and uncontrolled studies of ACCUPRIL where 918 (21%) patients were 65 years and older, no overall differences in effectiveness or safety were observed between older and younger patients. However, greater sensitivity of some older individual patients cannot be ruled out.

Pediatric Use

The safety and effectiveness of ACCUPRIL in children have not been established.

ADVERSE REACTIONS

ACCUPRIL has been evaluated for safety in 4960 subjects and patients. Of these, 3203 patients, including 655 elderly patients, participated in controlled clinical trials. ACCUPRIL has been evaluated for long-term safety in over 1400 patients treated for 1 year or more.

Adverse experiences were usually mild and transient.

Discontinuation of therapy because of adverse events was required in 4.7% of patients treated with ACCUPRIL in placebo-controlled hypertension trials.

Adverse experiences probably or possibly related to therapy or of unknown relationship to therapy occurring in 1% or more of the 1563 patients in placebo-controlled hypertension trials who were treated with ACCUPRIL are shown below.

Adverse Events in Placebo-Controlled Trials

	ACCUPRIL (N = 1563) Incidence (Discontinuation)	Placebo (N = 579) Incidence (Discontinuation)
Headache	5.6 (0.7)	10.9 (0.7)
Dizziness	3.9 (0.8)	2.6 (0.2)
Fatigue	2.6 (0.3)	1.0
Coughing	2.0 (0.5)	0.0
Nausea/Vomiting	1.4 (0.3)	1.9 (0.2)
Abdominal Pain	1.0 (0.2)	0.7

Clinical adverse experiences probably or possibly related, or of uncertain relationship to therapy, occurring in 0.5% to 1.0% (except as noted) of the patients treated with ACCUPRIL (with or without concomitant diuretic) in controlled or uncontrolled trials (N = 4397) and less frequent, clinically significant events seen in clinical trials or post-marketing experience (the rarer events are in italics) include (listed by body system):

General: back pain, malaise

Cardiovascular: palpitation, vasodilation, tachycardia, heart failure, hyperkalemia, myocardial infarction, cerebrovascular accident, hypertensive crisis, angina pectoris, orthostatic hypotension, cardiac rhythm disturbances

Gastrointestinal: dry mouth or throat, constipation, gastrointestinal hemorrhage, pancreatitis, abnormal liver function tests

Nervous/Psychiatric: somnolence, vertigo, syncope, nervousness, depression

Integumentary: increased sweating, pruritus, exfoliative dermatitis, photosensitivity reaction

Urogenital: acute renal failure

Other: amblyopia, pharyngitis, sinusitis, bronchitis, agranulocytosis, thrombocytopenia

Angioedema: angioedema has been reported in patients receiving ACCUPRIL (0.1%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with ACCUPRIL should be discontinued and appropriate therapy instituted immediately (See WARNINGS).

Clinical Laboratory Test Findings

Hematology: (See WARNINGS)

Hyperkalemia: (See PRECAUTIONS)

Creatinine and blood urea nitrogen: Increases (>1.25 times the upper limit of normal) in serum creatinine and blood urea nitrogen were observed in 2% and 2%, respectively, of patients treated with ACCUPRIL alone. Increases are more likely to occur in patients receiving concomitant diuretic therapy than in those on ACCUPRIL alone. These increases often remit on continued therapy.

* In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.



Division of Warner-Lambert Company
Morris Plains, New Jersey 07950

PD-103-JA-7164-A2(022)



The Science of Healing...The Art of Caring

Exceptional professional and recreational choices are yours in West Michigan. Due to rapid growth, the Butterworth Health System offers attractive professional positions in its 530 bed tertiary care teaching hospital, 4 affiliate hospitals, and 7 Med+Centers. Positions are available in pediatrics, medicine/pediatrics, internal medicine, surgery, orthopedic surgery, otolaryngology, radiology, and OB/GYN. Opportunities include group practice, partnership, and solo or salaried urgent care and outpatient practices.

Choose Butterworth Hospital in Grand Rapids, which serves a population of 700,000, plus a 13 county referral area, or a small community or rural environment at one of the affiliate hospitals. Grand Rapids is West Michigan's cultural, educational, and economic center. With Lake Michigan only 30 miles away and numerous forests and parks nearby, there are ample opportunities for recreation and entertainment. Listed below are a few of the many opportunities available.

- **Family Practitioner/Outpatient Practice** BC/BE family practitioner full-time, 4 1/2 days, Monday through Friday. Established satellite outpatient practice, offering continuity of care, no call and regularly scheduled hours. OB, call, and hospital practice optional. Full benefit package, competitive salary with quarterly and year-end bonus. Opportunity to work additional hours in Med+Center, if desired.
- **Family Practitioner/Private Practice** Three well established and thriving group practices at Butterworth Hospital desire to expand by adding an additional BC/BE family practitioner. Join existing groups consisting of 2 - 5 physicians, OB optional. Desirable call schedules, competitive salaries and benefit packages.
- **Family Practitioner/Urgent Care Center** Join the growing field of ambulatory care, Med+Center BC/BE family practitioner needed to provide medical services to patients on a regularly scheduled basis. No call schedule, flexible hours, excellent compensation and benefits.
- **Family Practitioner/Primary Care Clinic** BC/BE family practitioner or internist needed for a large, primary care medical and dental clinic in Grand Rapids. The clinic is managed by Butterworth Ventures, the largest health care system in West Michigan and funded by private donations and a federal grant. Staffing includes 2 family practitioners, a pediatrician, nurse practitioner, medical director and support personnel. This is a salaried position with a competitive compensation and benefit package and 1 in 5 call schedule.
- **Internal Medicine/Faculty Position** Board certified general internist with teaching and clinical skills needed to join dynamic full-time academic faculty for internal medicine residency. Responsibilities include direct patient care in faculty practice, supervision and teaching of residents and students in both outpatient and inpatient settings. Competitive salary and benefits. Protected time is available for research and teaching.
- **Internal Medicine/Emergency Medicine** Immediate opening for a BC/BE internist with emergency medicine experience. Join a rapidly growing group of internists who cover the Emergency Room and in-house patients at United Memorial Hospital in Greenville, Michigan (1 hour from Lake Michigan and 35 miles from Butterworth Hospital). Flexible hours, no call, excellent reimbursement and benefit package.
- **Multi-Specialty Outpatient Group: Family Practitioner, Med/Peds, Internal Medicine, Pediatrician**
Dynamic 7 physician multi-specialty group providing outpatient care at United Memorial Hospital seeks additional physicians. Full-time position, 4 1/2 days Monday through Friday with additional hours available in the urgent care center or Emergency Room. Located in Greenville, Michigan (1 hour from Lake Michigan and 35 miles from Butterworth Hospital). Call and inpatient care is optional with opportunities available to do procedures in the hospital or office. Competitive salary and full benefit package including malpractice

For information about the above positions, please call or write to
• Nancy Martens, Manager Medical Staff Placement 1-800-788-8410.
Butterworth Health System, MC 73, Nancy Martens, 100 Michigan NE,
Grand Rapids, Michigan 49503

■ letters to the editor

Preventing bicycle deaths

Is a bicyclist more like a pedestrian or a Mack truck? The bicyclist and the pedestrian each weigh about 150 pounds, and the truck weighs 80,000 pounds, 500 times the weight of the bicyclist.

The obvious answer is the bicyclist is much more like the pedestrian. This then begets the question of why the bicyclist has been legislatively relegated to the right side of the road to compete for roadway, space and survival with semitrailers, cars, vans and all the assorted motorized vehicles that bear down on him from his unseeing backside and their blind side?

The odds of survival in the right lane become even more infinitely remote when we consider energy and velocity. $E=1/2mv^2$, where m equals mass and v is velocity. The semitrailer has approximately 12,500 times the energy of the bicyclist.

How could any legislative body in its right mind do this to a bicyclist?

These questions never occurred to me until at least 20 years ago, when I became involved in a coroner's case involving a bicycle fatality and about the

same time started riding bicycles with my children.

The Parke County coroner called me to help determine the cause of death of a young female college student, who was killed as she rode up a small hill on U.S. 41 near Turkey Run State Park. A semitrailer drove up behind the woman and either never saw her or misjudged his distance from her, striking and killing her. She died of massive head injuries and a fractured cervical spine.

At about the same time, I was enjoying bicycle riding with my children. I always felt uncomfortable riding on the right side where I couldn't see an approaching vehicle behind me. I usually rode like a pedestrian walks, on the left, facing traffic, and sometimes even rode on the sidewalk facing traffic. Doing thus, I noticed when I looked the driver in the eye he would swerve away from me, even though I was off the side of the road and he didn't have to do so. I noticed that they seldom swerved away when I had my back to them.

Bicyclists killed in accidents are usually hit from behind. They can't see what is coming, nor how close they are to the approaching

vehicle. The driver cannot judge well the distance between his right fender and the bicyclist. Neither a bicycle nor a motor vehicle follows a straight trajectory. They bobble and weave from side to side. It is double jeopardy, causing so many people to die from bicycle accidents each year.

Truckers now want double and triple trailers that may be twice as long and weigh twice as much. These belong on the rails and not on the road.

For the safety of ourselves, our families and our patients, I recommend that the ISMA lobbyists persuade our state and national legislatures to pass legislation requiring bicyclists to ride on the left side of the road with pedestrians and not let trucks get any longer or heavier. We physicians also should send this article to our legislators recommending they change the law.

There will be no significant strides to reduce bicycle deaths until the bicyclist is moved to the left side of the road. □

Frank Swaim, M.D.
Rockville

Medical Economics corrected

Editor's note: The following letter was sent from C. Dyke Egnatz, M.D., ISMA president, to James Gray, senior editor of Medical Economics, in response to an article in the Jan. 20, 1992 issue of Medical Economics. The article incorrectly says: "Indiana not only has no reporting law for doctors, its board can't do anything about a problem doctor - even if a board member sees the problem himself - until someone files a formal complaint with the attorney general."

Dear Mr. Gray:

Your assertion that Indiana has no reporting law for doctors is clearly in error ("Why bad doctors aren't kicked out of medicine," Jan. 20, 1992 issue). Indiana law requires that a practitioner who has personal knowledge of illegal, unlawful, incompetent or fraudulent conduct by another practitioner must report it to the peer review or similar body with jurisdiction in the matter. The law specifically permits reports directly to the Medical Licensing Board. (See

enclosed copy of 844 IAC 5-2-8.) Certainly a Medical Licensing Board member in Indiana has the same duty to report under this law as other practitioners do.

Nor does Indiana's legal definition of "professional incompetence," as indicated in your article, require proof a doctor did something "intentionally" (844 IAC 5-1-1 also enclosed).

C. Dyke Egnatz, M.D.
ISMA President

■ letters to the editor

Baby bottle tooth decay

Communal water fluoridation, fluoridated toothpastes and regular visits to dentists have reduced dental caries in a large segment of the child population. So why do we still see baby bottle tooth decay (BBTD), also called nursing bottle caries, with such frequency? The results of a recent survey conducted in Indiana reported that a significant number of dentists often see infants and toddlers with rampant and nursing caries, while 73% of pediatric dentists see three or more cases monthly.¹ A comprehensive review of BBTD by Ripa reported a prevalence range from 1% to more than 50% in reports from various countries.² In Western-type cultures, that prevalence is usually about 5% or less.

In 1978, a joint statement from the American Academy of Pediatrics and the American Academy of Pediatric Dentistry made the following recommendations:

1. It is wise to teach infants to drink from a cup as they approach their first birthday.
2. The use of juices from a bottle should be discouraged; infants should be offered juice from a cup as soon as possible.
3. Nursing bottle caries can be avoided if milk bottle feeding is discontinued soon after the first birthday and if juice is always offered from a cup.

Although BBTD can be initiated as early as 12 months of age, parents frequently are not aware of the condition. The initial white demineralized area on the maxillary incisors rapidly progresses into a distinct carious lesion which circumferentially involves these teeth. The mandibular incisors are unaffected since they are protected by the tongue while the maxillary incisors are bathed in the liquid (Figure).



Advanced state of baby bottle tooth decay with extensive caries of the maxillary incisors.

Treatment of children with BBTD generally costs several hundred dollars since many of these children are treated in a hospital facility.

Pediatricians, family physicians, pediatric dentists and general practice dentists must join forces to eradicate this preventable disease. We must form a unified approach involving preventive counseling. Some parents are totally uninformed about the etiology of BBTD, and others have been informed but need assistance with modifying behavior so that the child can be weaned off the bottle. Various media outlets like radio, television, newspapers and magazines can help educate many

parents, grandparents, babysitters and other infant caretakers. Prenatal and postnatal care providers should receive pamphlets directed to educate specific population groups. □

References

1. Henderson HZ et al: Indiana infant-toddler dental care survey. *J Indiana Dent Assoc*, 70(1):8-13, 1991.
2. Ripa, LW: Nursing caries: A comprehensive review. *Pediatr Dent*, 10:268-282, December 1988.

Hala Z. Henderson, D.D.S., M.S.D.
Professor of Pediatric Dentistry
Indiana University School of Dentistry, Indianapolis

Letters to the editor

INDIANA MEDICINE welcomes letters from readers. Please submit double-spaced, typed letters that are limited to 250 words and include your name and address. Letters may be edited for space, style and grammar.

Send your letters to George T. Lukemeyer, M.D., INDIANA MEDICINE, 322 Canal Walk, Indianapolis, IN 46202-3252. □

Health commissioner concerned about access to care



Dr. Bailey

John Christopher Bailey, M.D., has opinions, and he doesn't mind sharing them. After only 18 months as commissioner of the Indiana State Department of

Health, he speaks like a man who has a grasp of the public health issues in Indiana and has not wasted any time doing what needs to be done.

He clearly enjoys the work. One of the things he has learned about this job, he noted in a recent conversation with *INDIANA MEDICINE*, is that he would be delighted to be health commissioner for a long, long time. "It's been quite a challenge and a real opportunity to serve, one that doesn't come one's way very many times in a lifetime."

Dr. Bailey, who refers to himself as Chris Bailey, is the son of a country doctor from southern Indiana. He graduated from the Indiana University School of Medicine with honors and did his residency in internal medicine at St. Vincent Hospital and the Indiana University Medical Center in Indianapolis.

After serving as a U.S. Army Medical Corps artillery surgeon in Vietnam, Dr. Bailey returned to the I.U. School of Medicine in 1970 for a United States Public Health Service Trainee Fellowship in cardiology. With his subsequent appointment as research

associate at the Krannert Institute of Cardiology in Indianapolis, he began a 20-year career that encompasses widely published scientific research, professional consultantships, academic appointments, private practice and public service.

As state health commissioner, Dr. Bailey sees himself and his agency involved in the political process, going about an "apolitical mission." The role of the state health agency, he believes, is to "do our best to persuade and cajole" Hoosiers into healthier lifestyles, and he credits his staff with helping him to transform his "rubber truncheon" method of diplomacy into one of consensus building.

He is optimistic about his working relationships with members of the general assembly and other elected officials and about his future as commissioner. "I serve at the pleasure of the governor, so the way I calculate it, I probably have at least five more good years to serve."

Here are highlights of his interview with *INDIANA MEDICINE*.

INDIANA MEDICINE: What is the health department doing to improve the immunization rate in Indiana?

Bailey: The immunization rate is good in some respects and not good in other respects. Indiana, like most states, does an excellent job of immunizing or having children immunized by the time they enter first grade, or as a requirement of entering public schools. That rate is something like 98% or

99% of immunization, current immunizations for the usual childhood diseases.

Our problem in Indiana, and one that is being addressed throughout the country, is the inadequate rate of immunization of toddlers, of 2-year-olds and 3-year-olds, where childhood diseases can truly be devastating. In Indiana it's probably not much better than 50% of 2-year-olds are current with their immunizations, and that's true pretty much around the country.

First, there's a societal problem. People don't think of infectious diseases or childhood diseases as being serious diseases. The days of polio are over, when people went in masses for immunizations. Some diseases we think we've cured or eliminated, like smallpox. So I think overall people's level of concern about childhood diseases is pretty low. People of my generation, for example, think that, well, I've had all the childhood diseases and most of us survived.

The problem is there's no way reasonably to capture 2-year-olds. All the 2-year-olds in the state don't convene at one place at any one time in the year. Very recently we have organized a task force here at the state department of health that will address that specific issue. The task force is made up of pediatricians, infectious disease people, county health officers and concerned citizens, and their charge is in part to try to develop some mechanism whereby we will have a captive audience of preschool children to increase the immunization rate.

Another problem of course is the cost of immunizations. They're increasingly more expensive, partly because of the concerns of litigation. It costs \$70 or \$80 perhaps to immunize a child. If you have a household of four or five kids, it's quite expensive. Most third-party payors don't pay for immunizations, which I find to be unconscionable, almost. Yet they will pay for a lifetime of institutional care for somebody who develops measles encephalopathy and is a ward of the state thereafter.

In these days of fiscal crunch, the state government in general can't afford the increasing burden of providing more and more free immunizations, although we provide immunizations for perhaps close to half of the kids in the state who get immunized. Private physicians more and more don't keep the vaccines in the office because of short shelf-life, expense and fear of liability. So more and more kids are going to local health departments to get their immunizations, and these immunizations are provided free of cost because of certain requirements that the law imposes on not having means testing to get the immunizations.

We have another problem, too, and that is the citizen who is old enough not to have been required to have immunizations before entering first grade. You may recall two years ago there

were outbreaks of measles on several of the college campuses, and this required on the part of our department a rather massive and intensive effort at mass immunization of those students on campuses.

We've tried to address that issue twice now that I can recall, via the legislative process, in requiring that college students be properly immunized. This has not been successful, unfortunately, and one of our major opponents has been those people who repre-

medical records from family doctors' offices or pediatricians' offices, most of them are pretty compulsive to see that their patients are properly immunized.

Those who don't provide immunizations are certainly urging their patients to appear at the local board of health for these immunizations. I think the private physicians really do a pretty stellar job. The problem is of course that there are increasing numbers of Hoosiers who don't have access or don't avail them-

selves of access to medical care, especially fairly expensive out-of-pocket medical care, such as immunizations of several kids in a family.

INDIANA MEDICINE: There has been an increase in the number of

cases of tuberculosis nationally. Would that hold true for Indiana as well?

Bailey: It's not yet true for Indiana. In fact, the decline in cases of tuberculosis that we have enjoyed nationwide for quite a number of years is still continuing, at least [according to] the last report, in Indiana. However, we are certainly bracing ourselves for what we expect, for what my experts tell me to expect, to be a marked increase in cases of tuberculosis. And even more frightening, increases in numbers of cases of drug-resistant tuberculosis.

INDIANA MEDICINE: Do you have any thoughts on what is behind

Private physicians more and more don't keep the vaccines in the office because of short shelf-life, expense and fear of liability. So more and more kids are going to local health departments to get their immunizations ...

sent higher education in the general assembly, strangely enough, perversely enough. They consider the fiscal impact and the administrative hassle of keeping track of immunizations of college students apparently not outweighing the risk of an epidemic on their campus.

INDIANA MEDICINE: What can the individual physicians do in regard to improving the immunization rate in Indiana?

Bailey: I think the individual physicians are probably doing everything that's appropriate, everything they can do to improve immunizations. I think that as I hear about large reviews of

the national increase in cases of TB and what can be done about it?

Bailey: Certainly there are diseases on the increase that compromise affected people's immune systems, AIDS for example, and the incidence of tuberculosis is increasing rather remarkably in that group of high-risk patients, and drug-resistant tuberculosis, I might add. With increased homelessness, or perhaps increased awareness of homelessness and better medical tracking of these people, [tuberculosis] is certainly on the increase [in this population].

In other words, for people who don't take access or don't have access to adequate medical care, for the reasons we discussed, drug-resistant tuberculosis is on the increase and it's drug-resistant in many of these latter cases because patients can't afford the medications for the duration that they should be taking these. Oftentimes [that's] a year, sometimes more than a year, and oftentimes multiple drugs. And if the drug regimen is not followed completely and pretty religiously, these strains become drug-resistant, and some of them simply can't be cured with the current anti-tubercular medications.

What can be done about it, you asked?

INDIANA MEDICINE: I'm asking this in the sense of perhaps proactive kind of thinking since the increase nationally has not apparently manifested itself in this state yet.

Bailey: I think that we have our government for the last several

years to thank in part for keeping down that substrate that would allow tuberculosis to explode in this state. The state provides money from general revenues for tuberculosis surveillance, to buy anti-tubercular drugs, if need be. The local health departments, the local health officers around the state in the various counties are very attuned to the concern of screening people for tuberculosis, certainly those areas that are high risk.

There's a coalition of informed and concerned professional people throughout the state who are looking for ways to pre-

Bailey: Well, it makes it impossible. An association of medical examiners and county coroners, for example, is looking at ways to improve the accuracy of death records, causes of death. As long as it's a paper transaction rather than a more automated system of reporting and perhaps a more complete audit of medical records by concerned people like epidemiologists, it'll continue to be somewhat of a problem. As long as certain diseases, causes of death, bear a certain stigma, there will be that problem.

Clearly, as you pointed out, much of our epidemiological

With increased homelessness, or perhaps increased awareness of homelessness and better medical tracking of these people, (tuberculosis) is certainly on the increase (in this population).

vent those things that would allow tuberculosis to flourish. We're hosting here in the next week or two as well I think a pretty important symposium in cooperation with the lung association on the specter of a tuberculosis outbreak and tuberculosis epidemic in the state of Indiana, including those drug-resistant cases that we really anticipate will be on us sometime soon.

INDIANA MEDICINE: What is the state doing to improve the accuracy of death statistics? Inaccurate death records, among other things, make it difficult for physicians to do epidemiological studies.

work and much of our forecasting and much of our ability to identify unusual clusters of diseases, depends on information we get from records such as the death certificate. I think that it will always be a somewhat flawed system.

But those people who deal with the death records at our agency and those people who investigate deaths in the counties are cooperating to encourage a more accurate and, perhaps even more importantly, a more complete survey of the circumstances, say a hospitalization, terminal hospitalization, surrounding deaths in the state. We obviously can't force people, in any practical

way, to put down the right information. I think what is perceived as the right information is generally put down there. Sometimes not completely, but I think every good faith effort is made, almost always, to make it as accurate as the reporting physician perceives.

INDIANA MEDICINE: What is the role of the health department in the area of preventive care? Should it be more involved in this area or should individual physicians be willing to assume more of that responsibility?

Bailey: Well I think that prevention is probably the very soul of the state department of health, or a state department of health. And that's essentially what we do here. One [of the commissions we have here] has an important role in our regulatory function, hospitals and long-term care facilities and so on. I like to believe that through that mechanism we practice preventive medicine, in seeing that the state and federal and local regulations pertaining to these entities are enforced and are upheld, hoping that this provides the best possible clinical outcome for a morbid state. I think that's very clearly preventive medicine.

We have the state epidemiologist here and an epidemiology center that investigates diseases and outbreaks of diseases, whether it's infectious diseases or food-borne diseases, and very rapidly and very efficiently moves to the sources of these health problems. I think that's prevention.

We have a commission that does preventive medicine by providing maternal and child health care, by providing food supple-

ments to pregnant women and to infants. I think these are all preventive measures that are really what our agency exists for.

INDIANA MEDICINE: Are there areas where you as the commissioner feel the state health department should involve itself more and are there areas where you feel it would make more sense for individual physicians to become more involved in terms of prevention?

Bailey: In this day and age when there is something of a fiscal crunch throughout the country, and actually we're much better off here in Indiana as a state government than most places, there are limitations that are imposed by the fiscal implications of preventive medicine.

I think it's the role of a state agency, at least the state health agency, to do our best to persuade, to cajole, the citizens into healthier lifestyles. There are circumstances where our actions do have the force of law. It's a fairly frightening, if I may use the word, police power we have in certain circumstances to prevent disease spread. But certainly to the extent where we can educate intensively and repetitively about certain health practices, I think the sky would be the limit and the limit instead is the fiscal note.

At least from my perspective, growing up in a country doctor's home and then practicing cardiovascular medicine myself, I think that the colleagues that I'm associated with really do a very adequate job of counseling their patients in healthier lifestyles.

INDIANA MEDICINE: Does the

health department have a position in the debate on national health care reform, for example in the areas of universal health care, mandated coverage or the institution of a single payor system?

Bailey: Well, I don't think that the state health department has a position. I can assure you that the state health commissioner has a position on that. It's a personal conviction I have in these issues and obviously one, therefore, that I will try to develop and present in such a way as to hope that others would buy into the notion. So I think the opinion I'm about to give you is the opinion of Chris Bailey, M.D., who also happens to be the state health commissioner.

First of all I think there's no question in anybody's mind that the issue of health care in this country may be one of the foremost issues, not only over the back fence but also in the political debate going on right now. Because reform is sorely needed. And I think everybody agrees with that. Everybody from the most conservative to the most liberal agrees that there has to be some kind of reform. And I think that everybody agrees that it's irresponsible for us as a society to allow so many people to have inadequate access to medical care. Perhaps upwards of 40 million people in this country are affected by that, by the specter of inadequate or no health insurance. And I think that one can probably pretty scientifically and rationally link the lack of access to or availability of, health care, for whatever reason, to an increase in disease, preventable disease.

I think that there are certain

aspects of health reform, health care reform that are important. First of all I think that in this day and age everybody ought to have access to medical care. Everybody ought to have access. There ought to be universal access to a package of medical services that are fairly comprehensive. I'd look upon them as, for lack of a better word, let me say acute care illnesses, as opposed to long-term, custodial nursing home type care. I think that folks ought to have access to this no matter where they live, no matter where they work, or no matter whether they've changed jobs or not.

The system that I would see would be increasingly dependent on the emerging science of outcomes research. There are not many things that we do in medicine that we can go to the current literature and say, there's no question that this is the right thing to do. Clinical outcomes research is coming along, and increasingly what we provide patients in this universal health care vision I have will be based on that kind of scientific, rational examination of diseases and interventions.

I think that in order to practice that kind of medicine it will be important that the health care provider be freed somewhat from the fear of litigation. I think that we have to become less defensive practitioners. And about the only way we'll do that is to get some relief under the law, I think, although in Indiana it's a pretty good feeling to be able to practice and not have to order every test in the book for fear of a lawsuit.

I think that a universal health care system, certainly not in the foreseeable future, should not be a federal, federally operated, feder-

ally run program. I think that the various states or regions ought to be able to be allowed to make the less costly mistakes by experimenting with different kinds of health care reforms. Los Angeles County is not North Dakota, and the health care needs, access problems and transportation problems are just different, and I don't know how one can develop a health care system that would be applicable to Los Angeles County and Butte, Montana.

You ask about a single payor. I think that part of the inaccessibility that some may perceive to the system as it now exists is the myriad of forms and paperwork, not only that the patients have to worry about but the physician has

***I think that
in this day and age
everybody ought to
have access to
medical care.***

to worry about and the hospitals have to worry about. Every insurance company has a different form, every government source of insurance has a different form, and if it's not filled out right, you don't get reimbursed and it's an absolute nightmare. Doctors are hiring people by the droves just to keep books for them.

A single payor appeals to me, but it doesn't matter to me who the single payor is. I see a single payor as the issuer of checks and not as the formulator of policy. And I would want that single payor to be one who perhaps bids

competitively, who will do it with the lowest administrative overhead. Whether that's an existing insurance company, whether it's the state government, whether it's a Medicare office – Medicare doesn't do a bad job, by the way, in terms of administrative overhead in running that massive program – they would be the issuer of checks and not the makers of policy.

Now the money for those checks would come from a variety of sources. All the government sources of direct service providing could be funnelled into there. Private individuals, insurance companies, corporations, big business, the labor unions, the military, the VA system.

Health care reform is a curious problem and different from any I've thought about in my 51 years because we may be almost spending enough money for it already – an unconscionable amount of money. In my view it's just not being spent the right way.

We spend a huge amount of our total health care dollars in taking care of people in the first month of their life and the last month of their life. These are philosophical questions that other Western countries have seemed to come to grips with. We've never had to in this country. We've never thought we had to face the issue of "Is society going to continue to pay for the maintenance of a very very premature 500 gram infant who stands a good chance of not becoming a productive person, ever?" Are we going to continue to spend freely as we now do on futile efforts in a person's last illness? These are questions we have to address as a

society before government, before medicine, for that matter, organized medicine, can formulate policy.

INDIANA MEDICINE: Speaking of policy, what sorts of results do you see or anticipate from the state health policy commission's work?

Bailey: Well, it'll be interesting to see. What I'm aware of at this point is that they have taken a lot of testimony identifying what a great number of the problems are and then have reduced these problems to a few common denominators. At this point, I would suspect that the commission is in the process of trying to identify some solutions. Those solutions are not yet a matter of public record, but should be within the next few months.

They certainly have on that commission people who in my view have broad experience and have a clearer vision than most of what are the pervasive problems in the health care system as we know it right now. There are physicians that I have great respect for and business leaders for whom I have great respect. The chairman of the commission I have great respect for. He obviously has a great insight into the economics of the health care system as it now exists.

INDIANA MEDICINE: Has the state department of health been involved in the commission's work?

Bailey: Yes. We have provided the commission a lot of data regarding health related issues that are unique to Indiana, in fact re-

gions of Indiana. We think we have the most reliable data regarding diseases, rates of hospitalization, nursing home utilization, those kinds of data that are obviously critical to figuring out what are our problems and eventually how do you pay for them and how to allocate money to pay for acute care versus long-term care. These data have come from our department. Some of us also sit ex officio on that commission and so have been involved essentially from its start a couple of years ago.

INDIANA MEDICINE: Including yourself?

Bailey: I sit in there on occasion, yes. The commission was almost a year into its life when I became commissioner. But I have paid close attention to the proceedings of the commission.

INDIANA MEDICINE: You alluded earlier to the impact of budget reductions on public health programs. What areas, if any, will suffer in Indiana?

Bailey: Well, I look upon the fiscal situation of the state with great optimism, as a matter of fact. I hear stories of my colleagues in public health from other states who have suffered draconian cuts in their budgets. Ours have been exceedingly modest and present for us not a problem, I think, but a challenge to do things better, to do things more economically at this agency. And we've been able to do that.

We've organized the agency here in such a way that it's consumer, client-oriented, rather than agency-oriented. We have elimi-

nated some of the top management positions simply by having these top level people share responsibilities they didn't have before. We are trying to rather extensively cross-train middle managers and people that work for them in the various programs to be transportable to other programs and other public health initiatives. And we've not been faced with the concerns of having to lay off people and take job actions. We've not had to eliminate programs. We simply have been able in this agency to get the folks who work here to take on more than they were taking on when times were better. So I would expect nothing to suffer at this point because of the financial straits the country's in.

INDIANA MEDICINE: What's still on your "to-do" list, your agenda, as commissioner?

Bailey: I'm very interested in health care reform, as you may suspect from what we've talked about, and I intend to spend a lot of time and hope to develop an efficient use of staff time in looking at the various pros and cons of issues related to health care reform.

On a more practical, immediate level, you know that about half of the population in the state is rural, where access to health care is limited more than it is in the other half of the state that's metropolitan. And we are working in cooperation with other entities to establish an initiative that will I hope improve vastly access and quality of medical care in rural Indiana. I see this as in itself of great value to the state, but also in the context of Indiana, an

important component of health care reform.

So I would expect within the next year or so a major initiative in place in the area of rural health care. Perhaps it might be in the form of a model rural medical center, after forging with the private sector a partnership to develop a medical facility in an under-served area of the state. So

those are issues number one and two.

Really a sort of pie-in-the-sky ambition of mine would be to see eventually in the state of Indiana a school of public health. We don't have one, and there is no way in the state to get graduate training in public health at the master's level or beyond. I'd like to see that get off the ground

sometime within my lifetime, and I would hope that I have some impact on that. Those three things should consume me for the next 10 years, at least. □

This interview was conducted by Bob Carlson, a health care communications consultant in Indianapolis.

RBRVS MFS E/M CF AHPB
CHAOS
CPT GPCI RVU HCEA GAF



SAFE
EFFECTIVE
CONVENIENT
ECONOMICAL

Mono-Gesic[®] R Tablets
(750mg Salsalate)

A well tolerated
Salicylate Therapy



CENTRAL PHARMACEUTICALS, INC.

SEYMOUR, INDIANA 47274 USA

Quality Pharmaceuticals Since 1904

serenity.

Our accounts receivable management program
includes comprehensive service bureau billing,
expert profile review and coding assistance,
physician reports, and regulatory updates.

Isn't that just what you'd expect from the
medical billing expert? Call us today...
you can't afford not to.

 *Medical Accounts Group*
I N C O R P O R A T E D

3901 North Meridian Street • Suite 200
Indianapolis, IN 46208

IN (317) 923-3046 • USA (800) 527-6244

Indiana chosen for pilot project in risk management

Editor's note: See related editorial on page 192.

Indiana primary care physicians soon will have an opportunity to participate in a pilot project in risk management education.

The project, known as Practice Assessment/Quality Improvement (PA/QI), will begin in May in Indiana, one of eight states chosen as a pilot site. The Indiana State Medical Association and the Physicians Insurance Company of Indiana (PICI) are jointly sponsoring Indiana's participation in PA/QI. As a pilot site, Indiana will help determine whether PA/QI will become a model national risk management educational program.

The PA/QI program was developed by the Oregon Medical Association in collaboration with the Patient Safety/Risk Management Subcommittee of the AMA/Specialty Society Medical Liability Project (AMA/SSMLP). Other states selected as pilot sites are Georgia, Maryland, Missouri, New York, Ohio, Vermont and Virginia.

The three-part program for office-based primary care physicians will offer the following benefits to the 250 Indiana participants:

- the opportunity to have their office practice fully assessed from a patient safety/risk management perspective and to see how they compare to their colleagues nationwide;
- the opportunity to earn six category 1 credits toward the AMA Physician Recognition

Award for participating in parts 1 and 2 of PA/QI; and

- the opportunity to improve the quality of patient care, minimize patient injury and reduce the risk of malpractice litigation if they correct any deficiencies uncovered during the assessment.

AMA officials say the project should appeal to physicians because it was designed by physicians for physicians. Much of the groundwork for the program was laid by the Oregon Medical Association, which developed and tested the program with the help of physician volunteers. These physicians completed all three parts of the program, and their critiques resulted in improvements to the program.

The three components of the PA/QI are: 1) a self-assessment survey that inventories non-clinical risk management behaviors; 2) a home study course describing five hypothetical primary care physicians who have experienced multiple malpractice claims; and 3) a visit to your office by a risk management expert.

The self-assessment survey, which takes about 45 minutes to complete, includes 101 questions on such topics as scheduling appointments, handling phone calls, billing and collection procedures, diagnosis and documentation procedures. The PA/QI Registry will process the survey in a manner that ensures confidentiality. After enough surveys have been collected from all pilot sites to make the comparisons meaningful, each participant will receive a customized assessment report. The report will allow physicians to compare themselves to col-

leagues in similar practice settings and to change certain office procedures if they feel the results indicate improvements are needed.

The second part of the program is a home study course, consisting of a workbook containing five physician practice reviews. Each describes a hypothetical physician and his or her medical malpractice claims. Participants will review the hypothetical physicians' practice and behavior patterns and claims to determine what makes the physicians vulnerable to liability claims. Using resources provided by PA/QI, the participants will recommend how the physicians can reduce their liability claims and will determine if any of the hypothetical physicians' problems are present in their own practices. Physicians should expect to spend about five hours on this part of the project.

An on-site office survey is the third part of the project. This part will allow surveyors to observe which practices and behaviors identified by physicians in parts 1 and 2 of the program have been modified and how successful their effort has been. The survey also includes a review of 10 patient charts and individual interviews with the office staff and physicians. The visit concludes with a group meeting of physicians and the staff. Although the office visit lasts about four hours, the physician will be asked to spend only about one hour with the surveyors.

Paul Frisch said the office surveyors will focus on one or two key areas. Frisch, director of the medical legal affairs depart-

ment of the Oregon Medical Association and a member of the AMA/SSMLP Patient Safety/Risk Management Subcommittee, coordinated Oregon's PA/QI program.

The office visit is not intended to provide physicians with a "laundry list of all the bad things they've done in their life," said Frisch.

During the three to five years after the survey, PA/QI will perform a follow-up to see if the changes made as a result of the surveys have had an impact on the physicians' claims experience.

Frisch is optimistic that Indiana physicians will see the value of the program. He said that every physician who participated in the Oregon PA/QI project said they "got something out of it." He emphasizes that the project is not an attempt to find the "bad apples" among Indiana physicians since physicians with serious problems in their practice will not be likely to participate in the program.

Two hundred fifty Indiana physicians are needed for parts 1 and 2 of the program. Fifty of the 250 will be needed for part 3, the office visit. The enrollment period



Explaining the Practice Assessment/Quality Improvement (PA/QI) program during a meeting at the Indiana State Medical Association are, from left, Charlotte Miller of the American Medical Association's Department of Professional Liability and Insurance; Paul Frisch, director of the Medical Legal Affairs Department of the Oregon Medical Association; and Carla Brock, AMA Director of Communications Services.

will run from May 1992 to May 1993 for parts 1 and 2 and from May 1992 to December 1993 for part 3.

Participants should be in the specialties of internal medicine, family practice or pediatrics. At the completion of the initial pilot project, the program will be made available to physicians in other specialties.

The cost of the program to each participant will be a total of

\$125 for parts 1 and 2 and \$100 for part 3. The charge helps cover the cost of the materials distributed to physicians and their staffs and for the administration of CME credit.

Physicians interested in participating in the program should call Barbara Killila or Gene Reiss at PICI, (317) 469-4100 or 1-800-284-7424. □

Millions Victimized by Family Members Every Year!

Are you concerned about the effects of family violence and victimization within your community?

Become an advocate within your community for the prevention of family violence.

Violence among family members has reached staggering proportions. Every year more than 2 million cases of child abuse and neglect are reported, between 2 and 4 million women are battered by their spouses, and between 700,000 and 1.1 million of the elderly population are abused.

The American Medical Association has formed a *National Coalition of Physicians Against Family Violence*. Through the *Coalition* the American Medical Association hopes to involve you in activities that address issues of child abuse, sexual assault, domestic violence and elder abuse because you have the unique ability to identify the symptoms, first-hand. By joining the *National Coalition* you will be showing your concern about the effects of family violence and victimization, and will become a committed advocate within your community for the prevention of family violence.

Through the *Coalition* you will:

- be informed about local contacts and referrals
- become aware of local and regional resources
- be provided with information regarding model educational programs
- become aware of treatment guidelines and protocols.
- have access to newsletters, public education materials and other publications
- receive an official membership card and frameable poster alerting your patients of your interest in and concern for this problem.

The only **cost** to you **is your commitment** to help curb this problem. Simply complete the membership application form below and mail to the Department of Mental Health, American Medical Association, 515 N. State Street, Chicago, IL 60610.

Yes, include my name in the *Coalition's* membership

Name

Address

City/State/Zip Telephone #

Specialty

Auxiliary Member ☐ Yes ☐ No Other

Area of interest within Family Violence: ☐ Child Abuse ☐ Sexual Assault ☐ Domestic Violence
☐ Elder Abuse ☐ Other

American Medical Association

Physicians dedicated to the health of America



COMMITTED TO EXCELLENCE

*Roche
Laboratories
presents the
winners of
the 1991*



Please join us in honoring these outstanding Roche sales representatives who have distinguished themselves by a truly exceptional level of professionalism, performance and dedication to quality health care.

Throughout the year, each of these award-winning individuals has consistently exemplified the Roche Commitment to Excellence, and we're proud to invite you to share in congratulating them on their achievement.



Cynthia A. Armbruster

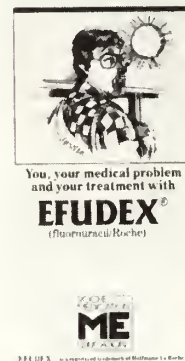
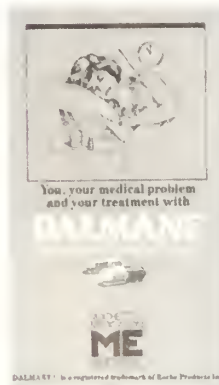
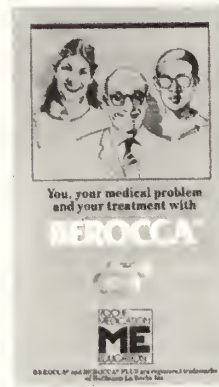
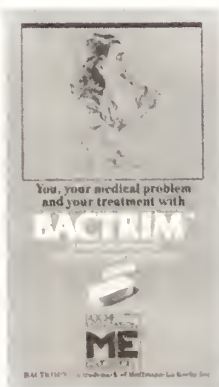


Frederick S. Ghanayem

COMMITTED TO TOTAL HEALTH CARE

*Roche
Laboratories
presents the
Resource Library
for patient
information*

ROCHE
ME
MEDICATION
EDUCATION

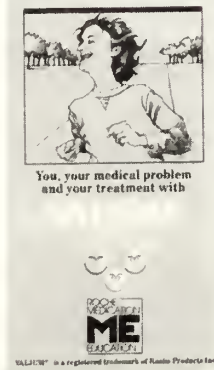
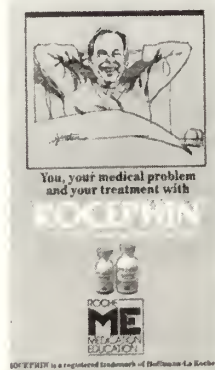
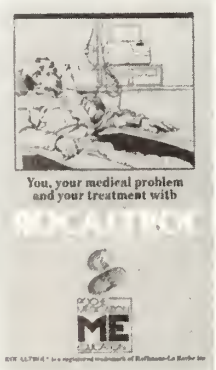
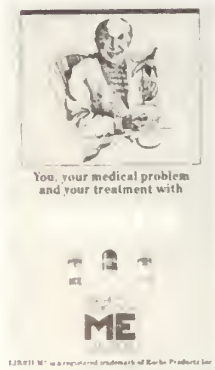


Your Roche representative offers you access – without expense or obligation – to a comprehensive library of patient information booklets designed to supplement rather than supplant your rapport with your patients.

Each booklet helps you provide...

- Reinforcement of your instructions
- Enhancement of compliance
- Satisfaction with office visits

Your Roche representative will be happy to provide a complete catalog of available booklets and complimentary supplies of those that are applicable to your practice.



ESRIN® is a registered trademark of Roche Products Inc.

FURTOB® is a registered trademark of Roche Products Inc.

GYNE ULTRA® is a registered trademark of Hoffmann-La Roche Inc.

ROCEPHIN® is a registered trademark of Hoffmann-La Roche Inc.

VALIUM® is a registered trademark of Roche Products Inc.

**CLAIMS
EXPRESS
TURNS
YOUR
INSURANCE
CLAIMS
INTO
CASH
FAST.**

**CLAIMS
EXPRESS**

You can turn your insurance claims into cash fast through Electronic Insurance Claims Processing. Call your local Claims Express affiliate today and hook into our ALL-PAYOR clearinghouse network.

Take advantage of the priority payment scheduling many carriers, including Medicare and Medicaid, give electronic claims. Claims that used to take three or four months for payment are often paid twice as fast.

Join the thousands of doctors already using this service that includes:

- Instantaneous on-line claims editing to eliminate 99% of all errors.
- Top billing rate coding to maximize allowable claims
- Competitive rates and fast, personal service

Entering the age of Electronic Claims Processing has never been easier or more affordable!

Authorized Agent

AMERICAN MEDICAL SERVICE

1099 N. Meridian Street * Suite 630

Indianapolis, IN 46204

(317) 630-3697

INDIANA EMERGENCY MEDICINE

For the widest variety of practice opportunities in emergency medicine, look no further than Spectrum Emergency Care. With over 450 client facilities nationwide, you're certain to find a perfect match to your personal and professional goals.

Spectrum Emergency Care offers:

- ◆ Flexible scheduling
- ◆ Occurrence-based malpractice insurance

- ◆ Administrative support
- ◆ Guaranteed fees

To learn more about the many exciting opportunities currently available in Indiana, contact Dan Fuller at 800/325-3982, ext. 7809.

**SPECTRUM[®]
EMERGENCY CARE**

A member of The ARA Group

Medical teams praised for rescue efforts

Polly Bigham
Evansville

J. Michael Burnley, M.D., was just finishing his shift in the Deaconess Hospital emergency department when a Kentucky Air National Guard C-130 military transport plane plunged into a hotel and restaurant on U.S. 41 south of the Evansville airport.

"One of the nurses came and got me right after the first reports came in over the police scanner," said Dr. Burnley. "When she told me that a big plane had gone down, my first response was 'Yeah, sure.' But then I looked out the window and saw the smoke rising from the crash, so I knew it was for real."

It was 9:52 on the warm, sunny morning of Thurs., Feb. 6, 1992.

No warning came through the airport control tower before the huge plane dived out of control, killing its five-member crew and 11 people on the ground.

Fortunately, the citywide response to the sudden disaster was a textbook example of how to provide coordinated rescue efforts, quick transportation to local hospitals and regional burn centers and excellent medical care for the 14 injured people. All three critically burned patients survived.

Emergency planners and medical officials praise Evansville's disaster response, claiming it averted more deaths from occurring. Both groups are convinced all their planning and drilling made an important difference.

Minutes after the crash, the first of 80 police officers, firefighters and emergency workers, 34 ambulances and several physicians were at the scene to aid people escaping the blaze set off by the 4,000 gallons of jet fuel exploding into both buildings.

Peter Stevenson, M.D., and Terry South, M.D., Evansville emergency physicians, were at a medical meeting a half block from the crash site when they heard a tremendous thud and felt the room shake. Then the lights went out.

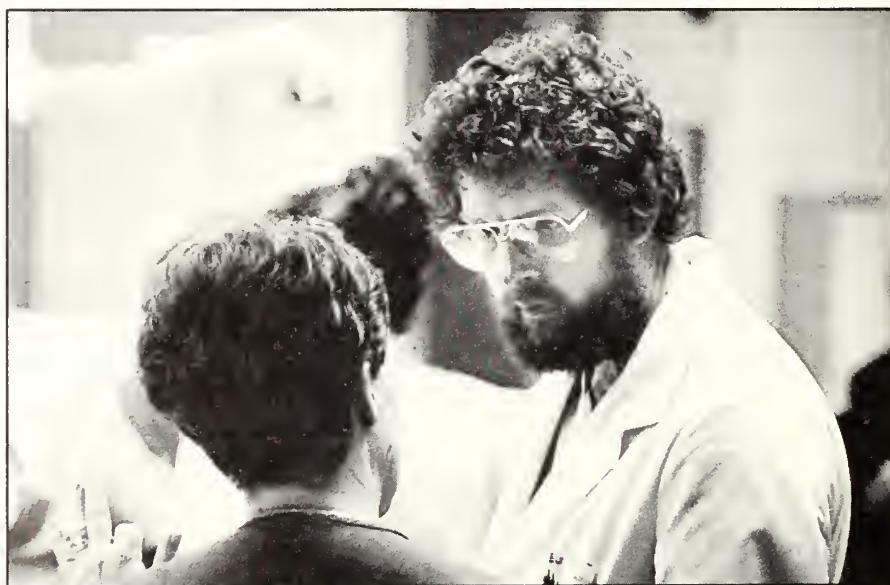
"We actually thought it was an earthquake," recalls Dr. Stevenson, who with Dr. South and a nurse rushed across the street to help.

After an unsuccessful attempt to reach two restaurant workers trapped inside, the two physicians

turned their efforts to setting up the medical triage area, seeing that the most critically injured were taken in the first ambulances.

"We didn't recognize and nobody did how many people were involved. There were people hanging out the hotel windows calling for help and a couple of people who stumbled out of the hotel on their own. We started the oxygen and the IVs and transported them as quickly as possible to the hospital. I was trying to mentally prepare for 30 or 40 casualties," Dr. Stevenson said.

Elsewhere, more than 90 doctors and 300 nurses were waiting at their assigned disaster posts at Evansville's three large hospitals, which all called red alerts within the first half hour. On hand were



J. Michael Burnley, M.D., talks with Sandra Chase, administrative director of Deaconess Hospital Emergency Department.

neurosurgeons, anesthesiologists, orthopaedic and respiratory specialists, surgeons and emergency physicians. The 34 operating rooms in the three hospitals halted their regular schedules to await the anticipated crash victims.

Timing played a role in preventing more casualties. Many observers have pointed out that if the plane had crashed one or two hours earlier, there might have been hundreds of breakfast patrons and most hotel guests wouldn't have checked out of their rooms yet. Because it was a weekday, each hospital also had 30 or 40 specialists making their morning rounds and a new shift of medical personnel just coming to work.

But Sherman Greer, executive director of the Vanderburgh County Emergency Management Agency, asserts that even if the hotel and restaurant had been packed, the emergency teams and medical facilities could have effectively cared for five times as many people who actually needed treatment.

Emergency medicine physician James Spiller, M.D., agrees. Dr. Spiller, who directs emergency services at Welborn Baptist Hospital and serves on an interagency consortium that oversees emergency services in the area, said, "All three hospitals responded very quickly. They all were prepared within 25 minutes after the crash to take 25 or 30 critically injured patients if that had been necessary."

The biggest problem was lack of communications from the crash site to the hospitals, according to hospital and emergency officials.

Rex Ragsdale, M.D., who as the medical affairs director at Deaconess is part of its command

hierarchy in disaster alerts, pointed out, "We were actually getting our information on how many casualties when the ambulances arrived at the hospital."

Dr. Burnley and Dr. Spiller agree that the communications snag was the main problem. Fortunately, however, that did not affect the medical care that day because the number of injured and killed was lower than first anticipated. But the two physicians agree that the communications must be improved before the next disaster hits.

Greer said the breakdown in the disaster plan occurred partly because emergency workers immediately began doing direct care for patients and failed to set up the communication system. But he is convinced they learned from that mistake and will follow the plan the next time.

Located four miles from the airport, Deaconess Hospital was the closest hospital to the crash site and received 11 of the 14 injured.

Dr. Burnley recalls, "We heard there were mass injuries. But actually we didn't get that many serious ones. I had envisioned, when they said there was a plane crashed into a hotel, seeing patients who had heavy beams or roofs fall in on them"

It turned out that all the critical injuries were caused by smoke inhalation and by burns. Because Evansville does not have a burn center, hospital helicopters from Wishard Memorial Hospital in Indianapolis and Welborn Baptist Hospital in Evansville played a key role in transporting the two most seriously burned patients to the Indianapolis burn center and to Humana Hospital-University of Louisville in Kentucky.

Kenneth Parker, M.D., an

anesthesiologist at Welborn, said its helicopter was getting warmed up as emergency physicians still were making final decisions about when to dispatch the two severely burned patients they were treating there to Humana's burn center.

Dr. Parker, who volunteered to accompany the patient on that flight, explains, "Burn patients are tricky to care for. A burn patient is kind of a disaster waiting to happen."

A veteran of numerous other emergency flights, Dr. Parker said, "There's nothing routine about that type of flying. You're always reassuring the patient. You're always checking to see if the blood pressure is up a little or down a little. In this particular case, for burns there is tremendous discomfort. But being an anesthesiologist and working with control of pain in patients, I'm pretty liberal with pain medication."

At the Louisville burn center, Hiram Polk, M.D., who is chairman of surgery at the University of Louisville Medical School and part of the medical team that treated the Evansville crash victims, commended the work by Evansville physicians.

Opened last July, a \$640,000 morgue designed to handle a major disaster proved itself a first-class facility, according to John Heidingsfelder, M.D., a forensic pathologist who serves a 30-county area of southern Indiana and southern Illinois. Dr. Heidingsfelder and Robert Penkava, M.D., an Evansville radiologist, helped with the positive identification of the 11 civilians. Dr. Heidingsfelder then performed the autopsies aided by a colleague from Bedford, James M. (Mike) Jacobi, M.D.

"The military were very con-

James Jenison, M.D., (center), talks to Jess Roberts, (right) director of Deaconess Hospital Emergency Medical Services, and a paramedic from Alexander Ambulance Services.



genial and very non-territorial. They came here with the understanding the local authorities were the ultimate authorities and we worked side by side," said Dr. Heidingsfelder.

Evansville medical groups and emergency planners say other improvements to the city's disaster plan, in addition to the new regional morgue, included a more powerful central dispatch system and expanded staffing and fund-

ing of its emergency management agency. In the last several years, that agency has spearheaded interagency task forces to fine-tune the city's medical and emergency services.

Evansville hospitals said their twice annual disaster drills and fine-tuning of their disaster plans also worked well in better preparing them for this disaster.

Emergency and medical officials said now is the time for them

to learn from this disaster, so next time they'll be even more prepared. One improvement has been debriefing sessions with emergency response workers to stress how the first people to arrive at the crash site are responsible to set up the communication system to report casualty numbers to the hospitals on the Indiana Hospital Emergency Radio Network.

Greer also will formalize an arrangement with the smaller outlying hospitals to take some Evansville patients who could be transferred there in the case of a disaster involving 300 or more injured. Another project is to plan another disaster drill involving all three hospitals. That was last done in 1990, and hospital officials agree it's time to do it again.

Dr. Burnley said the Evansville crash "just brings home to everybody that disaster planning is important and it's more than just a routine exercise we usually view it as. I think I'll have a little different attitude from now on." □

The author is a staff reporter for The Evansville Press.



ARNETT CLINIC

Lafayette, Indiana

About the Multispecialty Medical Group

Arnett Clinic has served Tippecanoe County and surrounding counties in Mid-North Central Indiana since 1922. Arnett physicians introduced the area's first dialysis service, performed the area's first open heart surgery, and developed the community's first heart catheterization laboratory. In four outpatient facilities, over 85 specialists and subspecialists provide medical and surgical services in virtually every specialty field. The bulk of Arnett's referral patients reside within a fourteen-county area surrounding Lafayette, Indiana, with a drawing area of over 300,000 people.

Ambulatory walk-in clinics in Lafayette and West Lafayette supplement primary clinic services. Arnett Urgent Care Centers are open from 8 a.m. until 8 p.m. every day, and staff members provide diagnosis and treatment for any medical problem which does not require ambulance transport.

Arnett physicians provide hospital support services at two nearby community hospitals, Home Hospital with 365 beds, and St. Elizabeth Hospital with 375 beds. Arnett has diversified into other healthcare fields, including Arnett Health Systems (an HMO) and the corporate affiliates of Arnett Medical Supply and Arnett Pharmacy.

Opportunities

The Arnett Clinic is currently seeking BE/BC candidates: Non-invasive Cardiology, Dermatology, General Internal Medicine, OB/GYN, Orthopaedics, Pediatrics, Urology.

Practice Setting

At this time, over 85 physicians work for Arnett Clinic. One of the most practical reasons for affiliation with Arnett is the availability of ancillary staff to support clinic operations. Administrative, Laboratory, and Radiology services are available on-site, making our practice environment an integrated, comprehensive, and convenient healthcare resource center. The patient base in Lafayette stems from a balanced mix of industrial and university communities. We are an equal opportunity employer.

Benefits

Our Medical Staff members enjoy competitive salaries and a generous benefit package. During the first two years of employment, Arnett offers a guaranteed minimum salary with a production bonus. After two years of successful practice experience, shareholder status with a productivity incentive formula is available. An excellent profit-sharing and investment plan is also available.

Other benefits include health coverage via Arnett HMO or other group insurance, disability, and life insurance plans. A generous fund for continuing education is available to clinic physicians.

Community

Lafayette, Indiana is a thriving, low-crime community located in a county of approximately 132,000 people. Purdue University, known for academic leadership in the areas of engineering, agriculture, humanities, and sciences, and for Big Ten Sports, is nearby. *Money Magazine* recently identified Lafayette as one of the top 14 cities in which to live in the U.S.A.

For more information, please contact:

John C. Horner
Director of Physician Recruitment
Arnett Clinic
2600 Greenbush Street
Lafayette, IN 47904
(317) 448-8000
Toll Free Nationwide, 1-800-899-8448

A#



NEW INDICATION

ONLY ONE H_2 -ANTAGONIST HEALS REFLUX ESOPHAGITIS AT DUODENAL ULCER DOSAGE. ONLY ONE.

Of all the H_2 -receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage.

Axid, **150** mg b.i.d., relieves heartburn in **86%** of patients after one day and **93%** after one week.¹

AXID[®]
nizatidine

150 mg b.i.d.

ACID TESTED. PATIENT PROVEN.

AXID[®]

nizatidine capsules

Brief Summary: Consult the package insert for complete prescribing information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests: False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions: No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility: A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, prenatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C: Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic: Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular: In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS: Rare cases of reversible mental confusion have been reported.

Endocrine: Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic: Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental: Urticaria was reported significantly more frequently in nizatidine than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity: As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other: Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

PV 2093 AMP [101591]

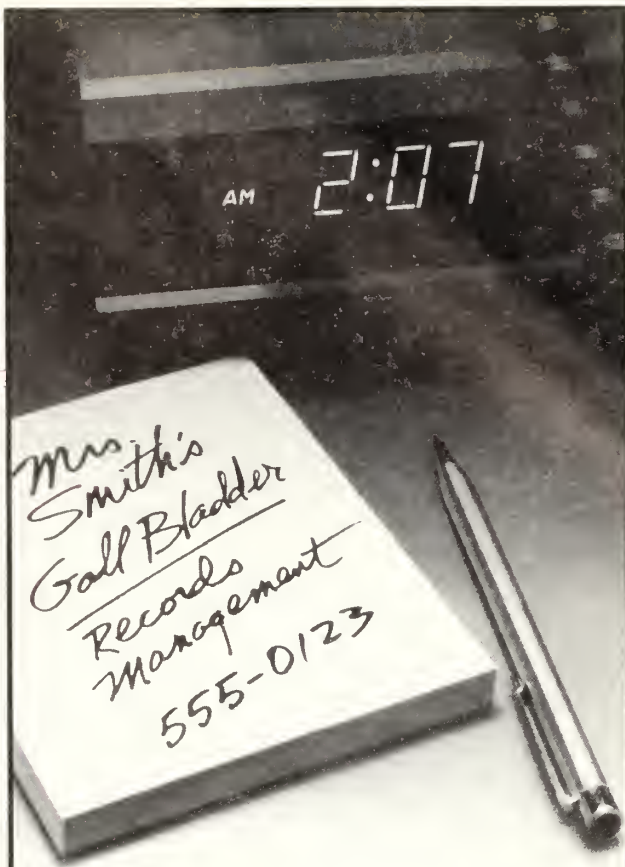
Additional information available to the profession on request.



Eli Lilly and Company
Indianapolis, Indiana
46285

NZ-2947-B-249304

© 1991, ELI LILLY AND COMPANY



If you are dedicated to health care why waste your time finding old files?

Current patient records should be at your fingertips. No question there. But what about old records, paid up bills and even dated x-rays? Consider offsite records storage. It can help clean up the office, and add to your efficiency. Your records are kept nearby in safe and secure storage facilities, for a low monthly fee. What if you need them in an emergency? With just a phone call our 24 hour, 365 day service can retrieve the needed file and fax it to you at the hospital, probably in the time it takes you to get there. Call in Records Management Services, and talk to the people that have been taking care of professional business records needs for over twenty-five years.



Records Management Services Corporation
Where business records are treated like treasure.

1165 South Girls School Road
Indianapolis, Indiana 46231
317.244.9044

Ethical issues in withholding and withdrawing life-sustaining treatment

Gregory P. Gramelspacher, M.D.
Indianapolis

How should we care for patients who are dying? Advances in medical technology often enable us to prolong the life of hopelessly ill patients for an indeterminate length of time. Advances in medicine have given us the opportunity to take better care of patients, but the use of this technology is a double-edged sword. Should we do more just because we can do more? This is where ethics has its place in medicine.¹

Technological advances in medicine accentuate moral dilemmas, but technology is not to blame. Instead, it is the inappropriate use of technology that creates crisis.

Physicians must be prepared to make difficult clinical ethical decisions about the termination of life-sustaining treatment despite the uncertainty and ambiguity inherent in clinical practice.

Termination of life-sustaining treatment refers both to decisions to withhold treatment as well as to decisions to withdraw medical treatment once it has begun. While some physicians may be more comfortable withholding treatment as opposed to withdrawing treatment, it is often better to initiate a treatment with a plan for stopping it if it proves ineffective rather than to withhold a treatment altogether for fear that

stopping it will be impossible. A trial of therapy will often lead to more certainty about the course of the disease and also give the patient and family time to understand the diagnosis and prognosis. Decisions to withdraw medical treatment should undergo the same ethical analysis as decisions to withhold treatment.

Medicine's most difficult ethical dilemmas are provoked by decisions at the end of life at a time when doctors, patients and families confront final choices about when and how to stop life-sustaining medical treatments. Patients and providers confront difficult decisions not only about

decisions to limit life-sustaining treatment consists of four general principles. These principles are: 1) medical indications; 2) patient preferences; 3) quality of life considerations; and 4) socioeconomic factors.²

Medical indications – The first principle to consider is the patient's well-being, referred to as the principle of beneficence. Medicine's long tradition acknowledges that the proper goal of medicine is to promote the patient's health, cure disease, relieve suffering and to not harm the patient. The most important question to ask is "What are the indications for medical treat-

ment?" Ideally, the physician dedicated to patient care starts with a commitment to the patient – to always act in the patient's best interest and for

the patient's well-being. Therefore, ethical deliberation should begin with a realistic evaluation of the goals of medical intervention.

To clarify the indications for medical treatment, we need to explicitly include the goals of treatment as well as a discussion of their chance of success. Conflict often results if the probability of achieving treatment goals is not made explicit. Certainly few people would argue that if a medical treatment has no possibility of therapeutic success or benefit then we should not provide it. But even in the case of medical futility, communication with the patient and family about the goals

Termination of life-sustaining treatment refers both to decisions to withhold treatment as well as to decisions to withdraw medical treatment once it has begun.

the use of high-tech medical treatments such as ventilators and dialysis, but they also face difficult choices about the use of ordinary treatments such as tube feedings or antibiotics. During the past 20 years, we have reached a surprising degree of consensus about the principles that need to be considered when faced with decisions to limit life-sustaining treatment. This article describes a systematic approach to use when confronting ethical dilemmas at the end of life.

Decision-making strategy for ethical problems in medicine
A systematic approach to analyze

of treatment must be explicit so the patient's goals for treatment are not incompatible with what the health care providers believe is possible.

Sometimes the physician's attempt to restore the patient's health or to prevent death and disability conflicts with medicine's other important goal – to relieve the patient's suffering. A physician who sees death as the final end to a patient's well-being will have a different approach to this problem than a physician who sees the patient's death as a natural end to life. Doctors often try to cure disease only to learn that cure is impossible. We must help patients with chronic and progressive diseases live as fully as possible. When a disease can't be cured, caring becomes paramount. It is helpful to recall medicine's ancient aphorism: cure sometimes, relieve occasionally and comfort always.

Historically, physicians have dominated medical decision-making, but during the past 20 years, patients have reclaimed their right to be involved in treatment decisions. In fact, the pendulum has swung away from medical indications to patient preferences. In the past, when physicians used medical indications to make a treatment decision, they were derided as paternalistic. Now most physicians acknowledge that the ideal doctor-patient relationship balances the indications for medical treatment with patient preferences.

The patient's preferences – The second principle to consider in the systematic approach to ethical decision-making is the patient's preferences. Patient autonomy is the underlying ethical principle, and the patient's right to self-

determination is fundamental to ethical decision-making. Patient preferences are always a relevant, and often decisive, consideration in the resolution of the ethical problems that arise in the course of medical treatment. In American law, this was expressed by Justice Cardoza in the following statement: "Every human being of adult years and of sound mind has a right to determine what shall be done with his body."³ The patient is responsible for his or her own health and has the right to be adequately informed about the diagnosis, prognosis and options for treatment.

In applying the value of autonomy to decisions to forgo life-sustaining treatment, the patient is placed at the center of the decision-making process. This principle encompasses an assessment of the patient's competence and capacity to consent to treatment or to refuse treatment. The proper role for the attending physician is to determine the patient's decision-making capacity and then to inform the patient about the risks and benefits of treatment. The essential feature of informed decision-making is that the decisions should be a collaboration between patient and physician. Informed consent is a process that should be based on the patient's understanding and voluntary consent to treatment.

The ideal doctor-patient relationship balances the indications for medical treatment with patient preferences. Unfortunately, these two most important ethical principles do not resolve all the ethical dilemmas. Clinical medicine is not a perfect science but an imperfect art. A great degree of uncertainty surrounds the indications for medical treatment, especially

at the end of life. Critically ill patients are often unable to express their preferences for treatment. Even when they are able to make their wishes known, they may give ambiguous or conflicting choices about treatment options.

When the patient lacks decision-making capacity, respecting patient autonomy calls for an appropriate surrogate to make treatment decisions based on the patient's explicit directions. Although advance directives such as living wills are becoming more common, the patient usually has not left specific treatment instructions, and a surrogate decision-maker must act on the knowledge of the patient's values and beliefs. In the uncommon case when sufficient knowledge about the patient is unavailable, the decision to limit life-sustaining treatment should be made on the basis of how a reasonable person in the patient's circumstances would choose. Inevitably this discussion involves considerations about the patient's quality of life.

The patient's quality of life – The third principle to consider is the patient's quality of life. When the medical indications for treatment are uncertain and the patient's preferences for treatment are unknown and cannot be determined, the patient's quality of life becomes a major consideration. Despite frequent reference to the patient's quality of life during deliberations about limiting life-sustaining treatment, quality of life determinations are a highly subjective component of medical decision-making. Even though quality of life considerations are difficult to define precisely or to agree upon completely, these questions are inextricably part of

the hard decision-making at the end of life.

Ideally, quality of life considerations should be based on the patient's own values and world view. Unfortunately, it is precisely when the patient lacks the ability to make his or her preferences known that quality of life considerations may critically influence the opinion of surrogate decision-makers and the assessment of health care providers. When the patient's own preferences for treatment cannot be known, we must be extremely cautious in our assessment of the patient's quality of life. Empirical studies have shown little agreement between physicians' assessment of their patient's quality of life and the patient's own assessment.⁴ In addition, quality of life considerations may change dramatically over time and under different circumstances.

It is difficult not to reflect our own bias in quality of life discussions. In order to acknowledge this bias, it is helpful to state specifically whose interests are at stake in terms of the benefits and burdens of treatment rather than refer to an abstract notion of quality of life. Generally, all treatments that impose undue burdens on a patient without providing overriding or significant benefits – or that simply provide no benefits – may justifiably be withheld or withdrawn. In this sense, the form of treatment, its complexity or invasiveness is not the relevant factor – only the burden it imposes in relation to the benefit it brings. We may even consider the benefits and burdens to persons other than the patient as long as we specifically acknowledge whose interests are at stake and

how the treatment decision will affect the patient and others.

Some ethicists argue that quality of life considerations will lead us down a slippery slope toward policies that discriminate against vulnerable patients. Others believe it is possible in most cases to discern a minimum quality of life. Whenever quality of life considerations arise in treatment decisions, it is important to involve those who know the patient best. It is also sometimes helpful to have people with a more objective view review the case if uncertainty and confusion

met, it is useful to consider how socioeconomic factors may influence treatment decisions.

Socioeconomic factors – The final principle to consider when making decisions to limit life-sustaining treatment is socioeconomic factors and the cost of care. No longer can the medical profession hide its head in the sand and ignore costs as relevant to treatment decisions. The cost of medical care has catapulted to the front of every discussion in medicine, and financial concerns have disrupted every aspect of the doctor-patient relationship. Whereas once

Generally, all treatments that impose undue burdens on a patient without providing overriding or significant benefits – or that simply provide no benefits – may justifiably be withheld or withdrawn.

persist about the right course of treatment.

Quality of life considerations may be a decisive factor in the clinical decision to withhold or withdraw medical treatment when all of the following conditions are met: 1) the indications for the medical treatment suggest that the maintenance of organic life without attainment of the other important goals of medicine is likely to be the only accomplishment; 2) the preferences of the patient are not and cannot be known; and 3) the patient's quality of life falls below the threshold that can, on the basis of wide and objective criteria, be considered minimal. Even if all of these conditions are

physicians would never admit that the cost of treatment influenced patient care, we are now asked to consider the cost of every treatment decision. As a society, we can agree that the cost of medical care should be considered in budget debates, but it is more difficult to agree on specific details. Similarly in clinical medicine, we may be able to agree that a concern for justice or equity is the underlying ethical principle, but when we approach the patient's bedside, it is difficult to consider socioeconomic factors in individual decision-making.

Should we ever consider the cost of treatment to be decisive in individual treatment decisions?

Should we ever consider the burdens and benefits to persons other than the patient to be relevant when making decisions to limit life-sustaining treatment? Many would argue that the physician is accountable to the individual patient and not to the public, but this naive view ignores the fact that socioeconomic considerations are increasingly part of the practice of medicine.

As a general principle, socioeconomic factors – even when elevated to the level of social justice – should not override considerations of the other three principles in making treatment decisions. However, these outside factors may be relatively more important when all of the following conditions are met: 1) the goal of improving the patient's well-being is doubtful; 2) the preferences of the patient are not and cannot be known; 3) the quality of the patient's life is considered minimal; and 4) the socioeconomic factor in question is specific and notably burdensome to others, and the decision to limit life-sustaining treatment will make a difference in alleviating that burden. In this rare instance, an external review would be appropriate to avoid conflicts of interest, assure an objective evaluation and

provide accountability. An external review could be done by people who do not have an interest in the outcome, such as the institutional ethics committee, an ethics consultant or a court-appointed guardian.

Conclusion

Despite the uncertainty inherent in the clinical practice of medicine, physicians must be prepared to make difficult decisions about the termination of life-sustaining treatment. A systematic approach to use when confronting ethical dilemmas should include some discussion of each of the above principles. Occasionally one principle will be more decisive than another, but they should all be considered when making decisions about limiting treatment.

The question "What should we do?" does not have a purely technological answer or a scientific solution. Complex ethical problems in medicine are resolved by considering "the specificity of moral issues in medical practice, the particularity of cases and circumstances, and the concreteness of the stakes for those individual human beings who are involved in them."⁵

Despite the emotional heartache brought about by these deci-

sions and the constant need to emphasize more humane care of the dying, we have made remarkable progress in articulating a standard of care in clinical medical ethics. Debates and dilemmas will persist, but the commitment to shared decision-making and compassionate care for the dying will foster the practical wisdom needed to recognize when medical technologies should not be applied. □

The author is an assistant clinical professor of medicine at the Indiana University School of Medicine in Indianapolis and a faculty associate at the Poynter Center for the Study of Ethics and American Institutions in Bloomington.

References

1. Gramelspacher GP: Medicine, ethics, and front-page news. *Indiana Alumni*, 53(4):64, 1991.
2. Jonsen AR, Siegler M, Winslade WJ: *Clinical Ethics*. 2nd ed. New York, NY: Macmillan Publishing Company; 1986.
3. *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 105 NE 92 (1914).
4. Seckler AB, Meier DE, Mulvihill M, Paris BEC: Substituted judgment: How accurate are proxy predictions? *Ann Intern Med*, 115:92-98, 1991.
5. Jonsen AR, Toulmin S: *The Abuse of Casuistry: A History of Moral Reasoning*. Berkeley, Calif: University of California Press; 1988.

Valuing a practice for purchase or sale

John W. Kolbas, CPBC
South Bend

Your telephone rings. It's your partner's spouse. "Something terrible has happened, Jim has had a heart attack, he's gone."

Death, disability and divorce – the three D's that are not enhanced by glasses are thankfully not the most common reasons for you to have to value your practice, but these events do occur. The most common reasons for valuing a practice are for new associate buy-ins, buy-outs of associates leaving the practice, retirement and sale to a new entity or group.

Valuing a practice is an art, not a science. Although many specific formulas, including ratios of gross receipts and/or net income, are tossed about and often used to establish the value of a practice, in fact each practice and each situation giving rise for a need for valuation are unique.

Differences in patient mix, cost of operations, staffing, equipment, facilities, location and potential will affect the valuation. The buyer and the reason for the sale will also have a dramatic impact on what will be realized from a practice sale.

Often when a solo practitioner retires or chooses to relocate, a practice sale occurs. In such situations, both the buyer and the seller aggressively pursue the most advantageous position. In the entry of associates into ownership in a medical group, however, a somewhat different approach usually is taken and a different attitude assumed. Since buy/sell

agreements usually call for a payout under a formula very similar to the formula used for a buy-in, it is very possible that the seller in a transaction might also become a buyer under the same terms. Although the valuation process for the solo practice sale and the group practice buy-in/buy-out is similar, the actual transaction price and the structure of the arrangement are likely to be very different.

Hard and fast formulas for valuing practices without considering other factors often assure that either the buyer or the seller will be treated unfairly. When a buyer and a seller will not be practicing together, a poorly established price or transaction often is only a hard lesson learned. When a buyer and a seller plan to practice together, such as in a new associate buy-in, an improperly established value or transaction can lead to much ill will and perhaps a dissolution of a promising relationship.

Before analyzing the various assets and liabilities that are a part of a practice valuation, two critical concerns must be shared.

First, perhaps the most neglected part of the practice valuation for purchase or sale is proper tax planning. It is often possible for a buyer to pay more and a seller to receive more by structuring arrangements so required tax outlays are minimized. In reviewing transactions that have taken place, it is always disheartening to find buyers and sellers who have suffered as the result of poor planning.

Additionally, for groups, the most serious concern in practice

buy/sells is to be sure buy/sell agreements are written and that these agreements are periodically reviewed to reflect changes that may have occurred.

Remember our friend and your partner Jim, whose untimely demise has left you with a patient base you cannot handle, no one with whom to share a call, and overhead that must be reduced. He also left you with his spouse and children, whose family income has been reduced substantially. Ideally, Jim had an adequate insurance program to protect his family. Whether he did or not, you will have to discuss with his spouse or the executor of his estate the value of Jim's part of the practice. It is in the best interest of all parties that this valuation formula and the payment terms be in writing.

You and Jim may have clearly understood but only verbally agreed that good will would not be considered and that other assets would be reasonably valued to protect the interest of the remaining party. Still, these facts are not likely to prove very comforting to anyone under the described circumstances. Even if Jim shared that conversation with his spouse, economic hardship or simple recollection or misunderstanding can create major problems. Having attorneys, appraisers and other advisors arbitrate practice value because no agreements are in place is not only costly but extremely stressful. Every group, no matter what size, needs a written buy/sell agreement.

Solo practitioners, although not in need of buy/sell agree-

ments, should also take the time to analyze the value of their practices. Having this information available is invaluable in assisting spouses or other third parties in selling the practice should the practitioner be unable to participate.

In valuing a practice, assets are usually divided into two distinct classifications: hard assets, also known as tangible assets, and soft assets, also known as intangible assets.

Hard assets are assets such as accounts receivable, real estate, equipment, inventory and supplies. Soft assets are assets that may have value but are difficult to reach out and touch. Good will, a term used to define the value of a going concern, is the most common soft or intangible asset, but not the only one. Attractive lease arrangements and other contractual agreements that can be transferred to a buyer are also assets of the practice that may have value.

Offsetting the value of assets is the liabilities of a practice. Loans on real estate, equipment and loans that will be assumed by the buyer must be used to adjust practice value.

Equipment leases are often neglected in practice valuations but should be considered. A lease for equipment may represent both an asset and a liability. Failing to consider equipment leases can be very costly to all parties. Assuming lease payments on a piece of equipment that is no longer being used is not appropriate, nor is it appropriate not to pay for equipment that for some reason may

not be reflected on the practice's balance sheet.

The most common tangible and intangible assets in practice valuations are listed below. Proper tax planning is imperative to assure that the buyer and seller will receive optimum tax treatment. Since tax and health care law is ever-changing, the transaction structure of practice purchases and sales must constantly be reviewed.

Tangible assets

Accounts receivable – For practices not owning real estate, accounts receivable usually represents the largest single tangible asset. In valuing accounts receivable for buy/sell purposes, it is important to determine what receivables can

accounts receivable are then multiplied by a factor ranging from 70% to 85% to establish the estimated collectible value on the books. Note that this percentage is not the same as the practice's normal collection percentage.

The valuing of receivables for group buy/sell arrangements is a necessary part of the practice valuation process. For most solo practitioners, if a practice sale occurs, the receivables will be collected by the selling practitioner and not purchased by the buyer. Although the buyer may assist in the collection process, it is usually not in the best interest of the buyer to purchase receivables, and in many instances there are laws to prohibit the assignment of benefit payments under

certain government and other third-party reimbursement programs.

Equipment – In valuing equipment, several terms must

In valuing equipment for medical practice buy-ins or buy-outs, avoid the appraisal process when possible.

be deemed reasonably collectible. Although there are some differences of opinion, the schedule below represents a reasonable consensus of the aged value of accounts receivable.

Current – 98%
30-60 days – 90%
60-90 days – 85%
90-180 days – 65%
180-270 days – 50%
270-360 days – 35%

A common method used in valuing receivables is to remove from the receivable calculation any balances over one year old and balances on accounts that may be with attorneys or collection agencies. The remaining

be defined. Cost is the initial amount that was paid for an asset. Market value represents what a willing buyer and willing seller would agree to as value. Replacement cost represents what it would cost to buy or replace the asset today. Book value represents the difference between the cost and the amount that has been written off for tax purposes, i.e., depreciation.

In valuing equipment for medical practice buy-ins or buy-outs, avoid the appraisal process when possible. When equipment is appraised, there can be significant differences in appraisals of the same equipment. Since the property is used, it is not appro-

priate to simply use cost figures to establish value. Replacement cost figures could be used; however, some adjustment must be made to reflect the fact that the equipment has been used. Since in recent years the Internal Revenue Service has allowed the rapid write-off of equipment, it is also not equitable to use depreciated value.

One often used and equitable method to value equipment is to use the cost figure and to depreciate the equipment over a 10-year useful life. Using straight line depreciation over 10 years may result in a relatively close approximation of economic value. By using such a method, cost of appraisals and, more importantly, the conflict of widely varying appraisals can be eliminated. If at all possible, group practices should avoid the need for appraisals each time an associate enters or departs.

There are times when a straight line depreciation method is not the most equitable valuation method. Certain equipment conceivably could appreciate in value and, thus, must be valued by an appraisal. In an ophthalmology practice, equipment used for refractions might lose very little value over time. Likewise, with other specialties certain high-tech equipment might require a special valuation. Many buy/sell agreements also call for equipment that is in use to always be valued at 10% to 20% of original cost, regardless of age.

Real estate – Real estate valuations are most normally accomplished by having an appraisal of the property. Most buy/sell agreements provide for appraisers to be selected by each party, or for an arbitration process should there be disagreement on the first

appraisal.

Group practices should consider establishing the buy-out value for an associate's interest in real estate at the beginning of each year so that if an associate leaves a value will already have been established. Using such an approach can save the money the practice would outlay for appraisals and help avoid the ill will caused if appraisals provide significantly different values. If all parties in the group do not agree to a value at the beginning of the year, then the appraisal process should be followed.

Inventory and supplies – In most medical practices there is usually a two-to three-month inventory of medical and clerical supplies. Many agreements call for a valuation of inventory and supplies to be accomplished by taking the prior year's expenditures for medical and clerical supplies, dividing that number by four to arrive at the average that might have been expended over a three month period. Another valuation method is to actually inventory all items on hand and then value them by the last invoice price. The inventory of all items on hand certainly provides for the most accurate valuation; however, a physical count can require significant time, especially in a large practice.

Intangible assets

Leases and other contractual arrangements – Should the practice have a favorable lease or be participating in a favorable contract that can be assigned to a new buyer, a value can be attached to these assets. For example, if space is being rented at substantially below current market rates, a buyer might be willing to pay a premium to

maintain the right to this lower rent. Likewise, other favorable contractual arrangements that provide an income stream or reduced costs can be valued.

Good will – Good will represents the going concern value of a practice. Without question, there are certain communities where, in order to assure success, it is necessary to join a group or purchase a practice to have access to a patient population. In many other communities, a shortage of practitioners reduces good will considerations since it is possible for a practitioner to establish his or her practice and have immediate access to a patient base.

In analyzing opportunities, practitioners need to recognize the advantages by joining or purchasing a practice that is staffed, has adequate equipment, and provides necessary cash flow. If the new practitioner wanted to open a practice, he or she would be required to find space, recruit a staff and borrow adequate funds for the purchase of equipment and to meet cash flow needs. To avoid these concerns, it is not unreasonable that a buyer should pay something to an established practice. What to pay is directly related to the additional costs that might be associated with establishing a new practice, the need for additional practitioners in the community, and the potential to earn an income above that which would be earned without an equity outlay.

Obviously, most buyers do not wish to outlay monies for good will. This is especially the case where it is possible to establish a solo practice or join another group and earn a similar income. For this reason, in situations where it may be difficult to attract

an associate or where there is a shortage of practitioners in the area, it may be best to avoid requiring a substantial good will payment. In group practices, accepting the advantages of having additional associates to carry the costs of fixed overhead, as well as improve quality of life for current practitioners, may be more valuable than risking the loss of a potential associate over the issue of good will.

In the case of a practitioner joining a group, often an employer or employee relationship will have existed for a minimum of one to three years. Depending

being served, the fallout to the institution was often a continuation of patient admissions. The revenue stream from these admissions made it possible for the institution to pay substantial good will.

Under new fraud and abuse rules and under many state laws, transactions that have occurred in the past between institutions and practitioners can no longer be structured as they have been. As has always been the case, there will be creative methods for accomplishing ends; however, it is less likely that we will continue to see the same level of good will

has tax benefit until the time the buyer eventually sells the practice. At that time, the amount paid for good will can be used to increase the seller's basis and thus reduce the gain on the sale.

In general, primary care non-referral practices tend to command a larger payment for good will if good will is being considered. Patients will often continue to seek service at the same location even if there is a change in practitioners. Although specialty groups that are adding associates might be able to require a good will payment, usually solo practice specialists are unable to demand a significant good will payment, since there is no assurance to the new practitioner that referral patterns will remain.

Since most buy/sell transactions are still effected between groups and associates either joining or leaving the group, it is likely that good will will remain a nominal part of a practice's total valuation in group practice buy-ins and sales. Again, this is the case since a seller in a group practice buy-in often finds himself or herself as the buyer in a similar transaction for an outgoing associate. Should tax law change to allow for the deduction of good will, perhaps the intangible part of a practice valuation will increase. Now however, most practitioners are willing to defer good will as a part of the calculation in order to assure the entry of new associates to their practices.

It is still a buyer's market in most communities. As the number of practitioners increases and as control of managed care contracts in closed panel programs reduces potential patient base, values for the good will of a practice will increase.

Although there have been proposals to change current regulations, under current tax law, good will is not treated as an expense nor is it allowed to be written off over a period of years.

on contract terms, it is possible that the group has enjoyed some positive net income by the addition of the associate. Thus, even in groups where buy-ins occur without a valuation for good will, it is likely that the group has enjoyed some payment for its going concern value.

Often, good will has represented a significant portion of a practice valuation where institutions were involved in the practice purchase. Obviously, institutions have motivations above and beyond what might be generated by the practice in earnings potential. Although institutions often entered practice purchase arrangements to help assure care and access to care for the community

paid as has been the case previously.

Analyzing exactly what values are placed on good will is difficult. At times good will may be reflected in reduced compensation to the incoming associate or in the valuation of other assets. The IRS is sensitive to these issues and now requires an itemized recording of all assets that are exchanged. This includes allocations to good will and other intangible assets. Although there have been proposals to change current regulations, under current tax law, good will is not treated as an expense nor is it allowed to be written off over a period of years. Thus, from the buyer's perspective, good will is not an asset that

Knowing how to value your practice, being realistic about that valuation process and factoring in who the buyer will be are imperative in ultimately determining the value of your practice.

Every practice and every transaction is unique, and all parties should focus on the positive aspects of a successful conclusion to negotiations rather than on comparisons to actual or assumed

information regarding other practice purchases or sales.

Sound tax advice in the structuring of arrangements and legal advice to avoid fraud and abuse concerns is imperative to assure the development of win/win scenarios for all parties.

Taking the time to value your practice and regularly reviewing buy/sell agreements will help in your business and personal finan-

cial planning and help you to avoid both uncomfortable negotiations and unpleasant surprises. □

The author has been a medical practice consultant for the past 20 years and is the director of Crowe Chizek's Health Care Group. Crowe Chizek, a CPA and consulting firm, has eight offices throughout the Midwest, serving a national client base.

RVU x GAF x CF = ?

AMS can now provide solutions to your new MEDICARE - RBRVU problems

- * Quick, computerized, custom-designed coding conversions
- * Pre-printed, custom-coded SUPERBILLS for your office use
- * Identification of the new CPT/EM/EV codes for your practice
- * Calculation of your modifiers, GPCIs, RVU/AHPB based fees
- * Electronic processing of claims to our ALL-PAYOR network

AMERICAN MEDICAL SERVICES
1099 N. Meridian Street * Suite 630
Indianapolis, IN 46204

**For more information,
please call
(317) 630-3697**

■ drug names

Look-alike and sound-alike drug names

	NORTRIPTYLINE	PROTRIPTYLINE
Category:	Antidepressant	Antidepressant
Brand name:	Aventyl, Lilly Pamelor, Sandoz	Vivactil, MSD
Generic name:	Nortriptyline HCl	Protriptyline HCl
Dosage forms:	Capsules, liquid, solution	Tablets
	NORMOZIDE	NORMODYNE
Category:	Antihypertensive	Alpha/beta-adrenergic blocking agent
Brand name:	Normozide, Schering	Normodyne, Schering
Generic name:	Hydrochlorothiazide- Labetalol HCl	Labetalol HCl
Dosage forms:	Tablets	Tablets, injection

Benjamin Teplitsky, R. Ph.
Brooklyn, N.Y.

Look-alike and sound-alike drug names can be misinterpreted by a nurse reading doctors' orders or by a pharmacist compounding physicians' prescriptions.

Such misunderstandings can result in the administration of a drug not intended by the prescriber. Awareness of such look-alike and sound-alike drug names can reduce potential errors. □



SPECIALIZE IN AIR FORCE MEDICINE.

Become the dedicated physician you want to be while serving your country in today's Air Force. Discover the tremendous benefits of Air Force medicine. Talk to an Air Force medical program manager about the quality lifestyle, quality benefits and 30 days of vacation with pay per year that are part of a medical career with the Air Force. Find out how to qualify. Call

USAF HEALTH PROFESSIONS
COLLECT
(317) 848-5830



ISMA successful during 1992 legislative session

Mike Abrams
ISMA Director of Marketing/
Legislation

It happened so fast that, if you weren't paying attention, you might have missed it altogether. The 1992 legislative session ended virtually on the earliest possible date: Feb. 14. Legislators moved almost without recess, taking only one day off, to honor the birthday of Martin Luther King Jr.

The 1992 session was the shortest "short" session (30-day session) on record. Indiana statute allows legislators to work as late as March 15 to complete the work of the short session.

When the bill filing deadline had passed, House members had introduced 438 bills, and senators filed 464. Of those 902 bills, 268 were passed and sent to Gov. Evan Bayh for his approval or veto.

Before the session began, legislative leadership put the word out: "If it is controversial, don't ask for it this session." Legislators remembered the bruising they took when last year's activity required the governor to call two special sessions just to get a state budget and new legislative districts passed. Additionally, legislators are going to be required to run in those new districts this fall, and they did not want to go home to irate constituents on the eve of an important election.

Health care gets attention

More than 200 of the legislature's 902 bills were identified by ISMA staff as worthy of at least distant monitoring. The impact of these bills on medicine ranged from minimal to profound. In the final analysis, the session was quite successful for the ISMA. Several bills that we wanted were passed and, perhaps more importantly, several bills that we didn't want were stopped.

Several things occurred to help make this a successful session. ISMA's Peer-to-Peer Key Contact Telephone Tree has been growing in popularity since it was first established for the 1990 ses-

The telephone tree and Medicine Day greatly contributed to ISMA's success during the 1992 session. Among the laws that passed this year:

- House Bill 1182 requires all entities doing utilization review activities in Indiana to register with the Department of Insurance and meet state registration requirements, which are set out in the law.

- House Bill 1337 implements the federal requirement that all state Medicaid programs implement a drug utilization review program to monitor physician prescribing to Medicaid patients. Indiana's DUR law is widely

considered by other states as a model statute.

- Senate Bill 412 prohibits a court from requiring a petitioner in a civil commitment proceeding to be represented by an attorney.

More than 700 ISMA members from across the state now participate in the telephone tree, which is an effective way for ISMA staff to generate phone calls to legislators on breaking issues.

sion. More than 700 ISMA members from across the state now participate in the telephone tree, which is an effective way for ISMA staff to generate phone calls to legislators on breaking issues. Further, ISMA hosted a "Medicine Day" at the Statehouse Jan. 15. On Medicine Day, more than 20 physicians attended a morning briefing by ISMA staff. Following the breakfast briefing, physicians walked across the street to personally lobby their legislators about issues that were being discussed.

Some of the bills that were introduced but did not pass include:

- House Bill 1001 would have allowed patients to specify in a living will that they would like nutrition and hydration withdrawn in the event they become terminally ill or are in a persistent vegetative state.

- House Bill 1023 would have established a Canadian-style universal health care system.

- House Bill 1220 would have allowed the worker's compensation board (a board currently

made up 100% of attorneys) to adopt a fee schedule for physician reimbursement under worker's compensation.

- House Bill 1222 would have prohibited physicians from charging for the first hour of consultation with a patient or a patient's attorney if the patient's health became an issue in a legal proceeding (such as worker's compensation or civil commitment).

- House Bill 1395 would have provided state certification and a scope of practice for professional counselors.

- House Bill 1399, introduced by Rep. Dale Grubb for the ISMA, would have allowed physicians to test patients for HIV with general health care consent, rather than specific, documented consent.

There goes the neighborhood

Indiana's legislative session was especially successful when considering the battle with which our Ohio neighbors are involved. Legislation intended to expand access to health care under con-

sideration in that state includes a "mandatory assignment" provision that requires Ohio physicians to accept the Medicare allowed amount as payment in full for Medicare patients. As originally introduced, the legislation applied to all Medicare recipients, regardless of income. An amendment was added, however, to apply a "means test" to the provision. The means test that now stands in the law is 700% of the federal poverty level, which works out to be approximately \$46,000 per year.

Ohio's legislation also sets up a health insurance pool for people who cannot find private health insurance because of their high-risk status. The pool is to be funded by a 1% surcharge on life, health and accident insurance, and premiums paid by risk pool recipients based on income. The governing board of the pool develops a reimbursement fee schedule for physicians who provide services to risk pool participants, and the bill as it is currently writ-

ten prohibits a physician from denying services to a pool participant who presents himself to the physician unless the physician gets permission to deny services from the pool's governing board.

Access a national topic

Access to health care is being debated in virtually every state in the nation, as well as at the federal level. During the 1992 Indiana legislative session, presidential candidate Bill Clinton visited Indiana and is rumored to have told several state legislators that the health care issue is a ripe one, and that legislators should not underestimate the salience of the issue at this time.

The salience of the health care access issue has caused 35 to 40 bills to be introduced in Congress. Legislators are addressing the issue in a wide variety of ways, ranging from tax credits for health insurance vouchers to a single payor system. □

Delayed posttraumatic diaphragmatic hernia:

Case report and literature review

Barbara Taylor, M.D.
Alan Watanabe, M.D.
Gonzalo T. Chua, M.D.

A 36-year-old white man arrived at the emergency room complaining of acute onset of epigastric pain with nausea and vomiting. He had been having intermittent epigastric pain for several weeks but had otherwise been in good health. His medical history was pertinent for a prior automobile accident with a resultant subdural hematoma but no other injury.

Examination revealed mild

tenderness in the epigastrium. The results of the complete blood cell (CBC) count and amylase series (Figure 1) were interpreted

Abstract

The case of a 36-year-old man with an unsuspected delayed posttraumatic diaphragmatic hernia is described. This entity often presents with vague clinical symptoms and non-specific radiographic findings long after the initiating trauma has been forgotten. Therefore, the preoperative diagnosis of this entity is notoriously difficult, but failure to make this diagnosis carries a high mortality rate. A high index of suspicion must be maintained.

Figure 1: Chest x-ray from acute abdominal series.



initially as showing minor elevation of the left hemidiaphragm and platelike atelectasis at the left base with a small left pleural effusion, etiology undetermined. Tagamet was prescribed for the patient, who was instructed to see his family physician.

Twelve hours later, the patient returned to the emergency room with epigastric pain and vomiting. Exam again showed tenderness in the epigastrium. The results of the CBC count and amylase were normal. Serum glutamic oxaloacetic transaminase and serum glutamic pyruvic transaminase were elevated twice normal. The patient was admitted for possible biliary colic.

The next day the results of a gallbladder ultrasound were normal. The patient had a temperature of 100.6°F, bilirubin 1.4 mg/dL, creatinine phosphokinase of 670, and white blood cell count of



Figure 2A

12,400. A repeat chest x-ray (Figure 2A and 2B) and an abdominal computed tomography (CT) scan (Figure 3) were obtained. The posterior-anterior and lateral chest films demonstrated bowel herniated through the left hemidiaphragm. The CT scan showed omentum, colon and mesentery in the left hemithorax. Further discussion with the patient revealed that five years earlier he had been stabbed in the left lower chest. These wounds had been uneventfully sutured at another emergency room, and his family was not aware of this injury. This was the reason the information had been withheld initially. Surgical exploration confirmed an 8-cm rent in the left hemidiaphragm with incarcerated but viable colon and incarcerated infarcted omen-

tum. The patient recovered uneventfully.

Discussion

Delayed diagnosis of posttraumatic rupture of the diaphragm is a well-known problem. Three clinical phases have been recognized:^{1,2}

1. Initial or acute phase. This phase begins with the original trauma and ends with the apparent recovery of other injuries. The diaphragmatic rent goes undetected.
2. Intermittent or latent phase. The patient has intermittent chronic symptoms that closely resemble gallbladder disease, peptic ulcer disease, partial bowel obstruction or coronary artery disease.
3. Obstructive phase. May



Figure 2B

Figures 2A and 2B: Posterior-anterior and lateral chest x-rays.

occur at any time to terminate the latent phase. Delays up to 60 years³ have been reported. In this phase, incarcerated viscera become obstructed, leading to necrosis if not recognized. Correct preoperative diagnosis is extremely difficult.

Traumatic diaphragmatic hernia may be secondary to blunt trauma, usually motor vehicle accidents, or to penetrating chest or abdominal trauma, usually stab wounds or gunshot wounds. Although most traumatic diaphragmatic hernias occur secondary to blunt trauma, those presenting in a delayed fashion are most often from penetrating trauma.^{1,4} This occurs because blunt trauma of significant magnitude to rupture the diaphragm is often associated with other extensive injuries,

whereas stab wounds and gunshot wounds are more likely to be managed selectively and small asymptomatic diaphragm injuries are more likely to go undetected. This will allow them to enlarge over the ensuing months or years due to great pressure differences between the chest and abdomen.⁴

The most commonly herniated viscera are the bowel, stomach, omentum, spleen and liver. Most herniations occur on the left side, presumably because of the protective buffering effect of the liver and perhaps the mediastinum.^{1,4,6} It also has been proposed that this higher left-sided incidence may be partially due to the preponderance of left-sided penetrating wounds from right-handed assailants.¹⁰

The most valuable diagnostic tool is the chest x-ray, which is almost always abnormal, although the abnormalities may be non-specific and even confusing.^{2,5,7} If the diagnosis is suspected, passing a nasogastric tube or performing barium studies may be helpful. CT may be very helpful, as it was in this patient. At times, CT may be limited by its cross-sectional orientation, though it also may allow early diagnosis of small tears, with little or no herniated viscera.^{7,8} Ultrasound may show disruption of the diaphragm, but this technique may be limited by bowel gas.⁹ Magnetic resonance imaging may be a useful diagnostic tool in the future, but current experience is limited.¹⁰

Knowledge of this entity and

a high index of suspicion are most helpful. Left untreated, delayed posttraumatic diaphragmatic hernia with strangulated viscera carries an 80% mortality rate.⁴ □

Dr. Taylor is a radiologist with Decatur County Memorial Hospital in Greensburg. Dr. Watanabe is an internist with Bartholomew County Hospital in Columbus. Dr. Chna is a radiologist at Methodist Hospital in Indianapolis.

Correspondence and reprints: Barbara Taylor, M.D., Decatur County Memorial Hospital, Radiology Department, 720 N. Lincoln St., Greensburg, IN 47240.

References

1. Carter BN, Ginseff J, Felson B: Traumatic diaphragmatic hernia. *AJR*, 65:56-72, 1951.
2. Brown GL, Richardson JD: Traumatic diaphragmatic hernia: A continuing challenge. *Ann Thorac Surg*, 2:170-173, 1985.
3. Pipkin NL, Hamit HF: Traumatic perforation of the diaphragm. *South Med J*, 11:1743-1750, 1988.
4. Payne JH Jr, Yellin AE: Traumatic diaphragmatic hernia. *Arch Surg*, 111:17-24, 1982.
5. Gelman R, Mirvin SE, Gens D: Diaphragmatic rupture to blunt trauma: Sensitivity of plain chest radiographs. *AJR*, 156:51-57, 1991.
6. Scott RF, Engelbrecht HE: Traumatic diaphragmatic hernia: An unusual presentation. *Injury*, 4:292, 1988.
7. Holland DG, Quint LE: Traumatic rupture of the diaphragm without visceral herniation: CT diagnosis. *AJR*, 157:17-18, 1991.
8. Heiberger E, Wolverson MK, Herd RN, Jagannadharao B, Sun taram M: CT recognition of rupture of the diaphragm. *AJR*, 135:369-372, 1980.
9. Ammann AM, Brewer WH, Maull KI, Walsh JW: Traumatic rupture of the diaphragm: Real-time sonographic diagnosis. *AJR*, 140:915-916, 1983.
10. Mirvis SE, Keramati B, Buckman R, Rodriguez A: MR imaging of traumatic diaphragmatic rupture. *J Comput Assist Tomogr*, 12:147-149, 1988.

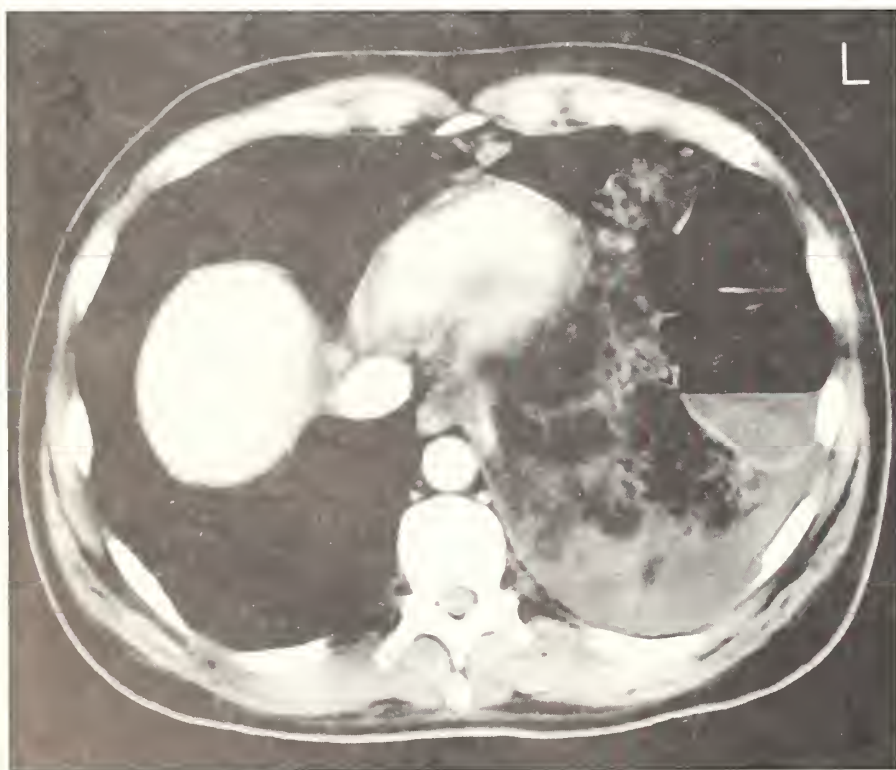


Figure 3: Upper abdominal computed tomography scan.

YOCON[®]

YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

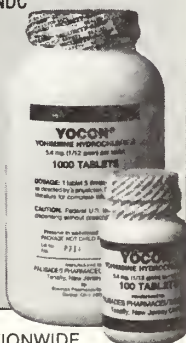
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



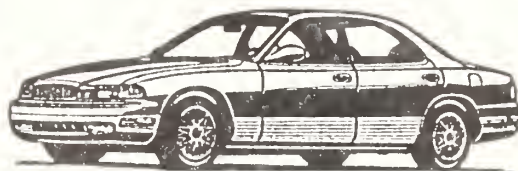
AVAILABLE AT PHARMACIES NATIONWIDE

**PALISADES
PHARMACEUTICALS, INC.**

219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

mazda

A REVOLUTION IN LUXURY CARS. THE NEW MAZDA 929.



Mazda 929 Luxury Sedan

Revolutionary in concept,
strikingly original in execution,
the Mazda 929 is
one luxury car that makes a
truly personal statement.

- 195-hp 24-valve V6 tuned for American driving conditions
- Roomy interior, centered around the driver
- Dual air bags - standard equipment
- Anti-lock Brake System - standard equipment
- New-generation multi-link suspension for ideal combination of ride and handling
- Special lease program

Find out for yourself today at
Indiana's #1 Mazda Dealer
(317)263-0002

Speedway Mazda
1935 W. 16th St.
Indpls, IN 46202

■ auxiliary report

Trudy Urgena
ISMA Auxiliary President



Trudy Urgena

This is an exciting time for the medical auxiliary. As we move through this decade into the 21st century, we are at the brink of change. Our membership is changing. We're more educated and career- and goal-oriented. We're becoming more informed and active in the legislative process. One-third of our potential members are male spouses. No longer are we just a fund-raising or a self-centered social group, but an organization dedicated to improving the quality of health across the state. Already we are actively identifying and addressing the health needs in our communities and are influencing health care legislation on the state and national levels. The image of auxiliary is in transition, and the national organization is considering a name change or modification to reflect our changing nature.

It is my privilege to have the

opportunity to lead the ISMA Auxiliary during this era of dynamic changes. The members are the organization's greatest asset, and we will use our talents, skills and volunteer time to help the citizens of Indiana lead healthier and more productive lives. When called upon, we will assist the ISMA in its endeavors and help in accomplishing its goals. Working together, we can realize our full potential and achieve the highest ideals of the medical profession.

This is the auxiliary team challenged with shaping the organization's future vision and steering it into the 21st century:

ISMA-A executive board

President – Trudy Urgena, Marion
President-elect – Sue Greenlee, Kendallville
Immediate past president – Kay Enderle, Terre Haute
Northern area vice-president – Valerie Gates, Valparaiso
Central area vice-president – Sue Schneider, Indianapolis
Southern area vice-president – Pat Walker, Terre Haute
First vice-president – Darlene Haddawi, Bloomington
Recording secretary – Loretta Madura, Indianapolis
Finance secretary – Hulda

Classen, Elkhart
Treasurer – Alexis O'Yek, Schererville
Executive director – Rosanna Iler, Indianapolis

County presidents

Lisa Conner, Bartholomew-Brown
Debbie Smith, Carroll
Elda Duque, Clark
Pam Morgan, Delaware-Blackford
Rita Poirier, Dubois
Barbara Piaskowy, Elkhart
Theresa Johnson, Floyd
Terry Wallace, Fort Wayne/Allen
Marla Keppler, Grant
Lee Ann Hughes, Howard
Monette Draper, Indianapolis
Ellyn Arnold, Johnson
Judi Moss, Knox
Sylvia Henry, Lake
Ramona Hay, LaPorte
Lura Stone, Noble-LaGrange
Linda Calli and Sharon Cofield, co-presidents, Owen-Monroe
Pamela Harris, Porter
Helen Mathis, St. Joseph
D.J. McPherson, Tippecanoe
Patty Lackey, Vanderburgh
Anita Davis, Vigo
Stacie Smith, Wayne-Union
Lisa Kerr, Wells □

NO QUITTERS.



We fight nonmeritorious claims. It would be easier to settle, and often less expensive for us. But we're not just insuring your financial future. We're guarding your professional reputation, an asset no amount of insurance could replace. So we put it in writing that we'll never

settle without your consent. We hire the best lawyers, back them up with the nation's largest malpractice law department, and win. If we didn't, we couldn't call ourselves The Medical Protective Company. Put us in your corner and call our general agent today.

THE
MEDICAL PROTECTIVE COMPANY

Vernon E. Hoover, H. Jere Frey, Michael W. Kinzer
6100 North Keystone Avenue, Suite 237, P.O. Box 20576, Indianapolis, IN 46220 • (317) 255-6525

Robert B. Newell, J. Barton Lyon
Suite 240, 2260 Lake Avenue, P.O. Box 5174, Fort Wayne, IN 46895 • (219) 422-4783

CARDIOLOGY - DIAGNOSTIC & INTERVENTIONAL



NASSER, SMITH AND PINKERTON CARDIOLOGY, INC.

William K. Nasser, M.D.

Michael L. Smith, M.D.

Cass A. Pinkerton, M.D.

James W. VanTassel, M.D.

Dennis K. Dickos, M.D.

John D. Slack, M.D.

Charles M. Orr, M.D.

Jane Howard, M.D.

James H. Adlam, M.D.

V. Michael Bournique, M.D.

Frank J. Green, M.D.

Nancy A. Branyas, M.D.

Charles P. Taliercio, M.D.

Bruce F. Waller, M.D.

Thomas F. Peters, M.D.

Lawrence E. Gering, M.D.

providing

Cardiology & Cardiac Catheterization

Transesophageal Echocardiography

Doppler & Echocardiography

Exercise Stress Testing

Coronary Angioplasty

Nuclear Cardiology

Pacemaker Surveillance

Holter Monitoring

Percutaneous Valvuloplasty

Electrophysiology Testing

Coronary Atherectomy

Myocardial Biopsy

Automatic Implantable

Cardioverter Defibrillator

Signal Averaged Electrocardiography

Nutrition Services

Cardiac Rehabilitation

Office: 317-871-6666

1-800-732-1482

1-800-CHD-PTCA

1-800-CAD-PTCA

FAX: 317-871-6019

With additional offices

located in:

Anderson • Brazil

Carmel • Kokomo

Marion • Terre Haute

Suite 400

St. Vincent Professional Building

8402 Harcourt Road

Indianapolis, Indiana 46260

THE HEART CENTER OF INDIANA

CARDIOLOGY

FORT WAYNE CARDIOLOGY

Basil C. Genetos, M.D.
Robert W. Godley, M.D.
Michael J. Mirro, M.D.
Kevin J. Kelly, M.D.
Fred Doloresco, M.D.
John F. Phillips, M.D.
Patrick J. Daley, M.D.
William W. Wilson, M.D.
James J. Heger, M.D.
Raymond E. Dusman, M.D.
Charles F. Presti, M.D.
Stephen E. Brown, M.D.
David D. Whang, M.D.

(Physician's Referral Only)

1912 Carew Street
Fort Wayne, Indiana 46805
(219) 482-4865 (800) 637-6505 (IN)
(800) 334-4371 (MI & OH)

Lutheran Medical Park
7900 W. Jefferson Blvd.
Suite 202
Fort Wayne, Indiana 46804
(219) 432-5613

Caring for people is the first priority at Fort Wayne Cardiology. Since 1978, our team approach has served referring physicians and their patients with the latest in heart care treatment and technologies.

Fort Wayne Cardiology is a trusted and caring group of people, featuring 13 board certified/board eligible cardiologists, as well as a special staff of nurses, technologists and administrative assistants. Patients are able to receive comprehensive cardiac services which include: cardiac catheterization, coronary angioplasty and atherectomy, electrophysiology, valvuloplasty, nuclear cardiology, doppler and echo cardiography, exercise stress testing, holter monitoring, ECG event monitoring, permanent pacemaker implantation and surveillance, non-invasive peripheral vascular evaluation, peripheral angioplasty and atherectomy, myocardial biopsy, transesophageal echo, AICD insertion and surveillance, signal average EKG, tilt table and rehab therapy.

University trained, certified cardiologists; the best in diagnostic equipment; clinical research and specialization within the specialty, makes Fort Wayne Cardiology an excellent center for heart care.

Angola
Auburn
Columbia City
Huntington

Kendallville
LaGrange
Wabash
Warsaw

Defiance, OH
Hicksville, OH

CARDIOLOGY

A new era in heart care has begun...

Now open



Robert E. Swint, Sr., M.D.

Mark A. Jones, M.D.

David A. Kaminskas, M.D.

Gary A. Hambel, M.D.

Mary H. Heintz, M.D.

Ravi N. Bathina, M.D.

Gregory C. Tomlinson, M.D.

Brian T. Lew, M.D.

Peter C. Hanley, M.D.

Christopher Zee-Cheng, M.D.

Steven W. Orlow, M.D.

David A. Belvedere, M.D.

Mark S. Hazen, M.D.

7836 W. Jefferson Blvd.

Fort Wayne, IN 46804

(219) 432-2297

800 Broadway, Suite 204

Fort Wayne, IN 46802

(219) 422-2558

3217 Lake Ave.

Fort Wayne, IN 46805

(219) 422-2297

2510 Dupont Rd.

Fort Wayne, IN 46825

(219) 489-8280

1-800-777-2297

CARDIOLOGY

Indiana Heart Physicians, Inc.

a member of the
Indianapolis Regional Heart Center
at St. Francis

Indianapolis/Beech Grove Medical Center
112 North 17th Avenue, Suite 300

Office	317-783-8800
Appointment Scheduling	317-781-3615
Cardiac Testing Center	317-781-3636
Toll Free (Nationwide)	800-992-2081

Consulting Offices at:

Greenwood
Shelbyville
Martinsville

Indiana Heart Physicians at Columbus
3154 North National Road, Suite C

Office	812-379-2020
Toll Free (Indiana)	800-331-4765

Physicians

H. O. Hickman, Jr., M.D., FACC
Thomas M. Mueller, M.D., FACC
J. Douglas Graham III, M.D., FACC
Kathleen H. Flohr, M.D., Ph.D., FACC
Jeffrey L. Christie, M.D., FACC
Stephen H. Kliman, M.D., FACC
Thomas C. Passo, M.D., FACC
Emily A. Diltz, M.D., FACC
John E. Batchelder, M.D., FACC
Mark D. Cohen, M.D., FACC
William J. Berg, M.D.
Thomas D. Hughes, D.O.
George E. Revtyak, M.D., FACC

at Columbus

David J. Hamilton, M.D., FACC
Kevin C. Preuss, M.D., FACC

providing

Cardiology and Cardiac
Catheterization
Coronary Angioplasty
Coronary Atherectomy
Electrophysiology
Percutaneous Valvuloplasty
Nuclear Cardiology
Stress Echocardiography
Exercise Stress Testing
Holter Monitoring
ECG Event Monitoring
Permanent Pacemaker Implantation
Pacemaker Surveillance
Color Flow Doppler Echocardiography
Laser Angioplasty
Trans-Telephonic Pacemaker Analysis

Noninvasive Peripheral
Vascular Evaluation
Signal Average EKG
Myocardial Biopsy
Tilt Table Testing

■physicians' directory

CARDIOLOGY

THE HEART CENTER OF MARION



Prakash N. Joshi, M.D., F.A.C.C.
Diplomate, American Board of
Internal Medicine & Cardiovascular
Diseases

Subodh S. Gupte, M.D., F.A.C.C.
Diplomate, American Board of
Internal Medicine, Cardiovascular
Diseases and Advanced Achievement
in Internal Medicine

providing
Cardiology
Electrocardiogram
Exercise Stress Testing
Doppler &
Echocardiography
Stress
Echocardiography
Holter Monitoring

**703 Chapel Pike
Marion, Indiana 45952
Appointments: (317) 664-1201
Business Office: 1-800-345-2035
FAX: (317) 664-2866**

Nasser, Smith & Pinkerton Cardiology, Inc.

PLASTIC SURGERY



AMERICAN SOCIETY OF
PLASTIC & RECONSTRUCTIVE
SURGEONS, INC.

John G. Pantzer Jr., M.D., F.A.C.S.
Diplomate, American Board
of Plastic Surgery

1801 North Senate Blvd., Suite 735
Indianapolis, Indiana 46202
317-929-5500

MERIDIAN PLASTIC SURGERY CENTER

For information on services
317/575-0110
or **800/352-7849**
106th & Meridian Streets
Indianapolis

An Ambulatory Surgery Center
Exclusively for Cosmetic, Plastic
and Reconstructive Surgery

Board-Certified Physicians

- Stephen W. Perkins, M.D., F.A.C.S.
- William R. Nunery, M.D., F.A.C.S.
- Ronald T. Martin, M.D.
- A. Michael Sadove, M.D., F.A.C.S.
- Barbara Siwy, M.D.



Facial, Ophthalmic & General
Plastic Surgery • Anesthesiology
Licensed by the Indiana State
Board of Health • Medicare
Certified

DOCTORS – This space is available.

For rates, write or call INDIANA MEDICINE,
322 Canal Walk, Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

DOCTORS – This space is available.

For rates, write or call INDIANA MEDICINE,
322 Canal Walk, Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

RADIOLOGY

SUPERB QUALITY DIAGNOSTIC RADIOLOGY AND RADIATION ONCOLOGY SERVICES ARE ONLY A TELEPHONE CALL AWAY...

Our mission is to provide caring, high quality, state-of-the-art imaging, interventional, and radiation oncological services to our patients, referring clinicians, and institutions. Call us today to discuss your unique requirements or to refer your patients for prompt, courteous, cost effective, and professional service.

INDIANAPOLIS

Methodist Hospital
1701 N. Senate Avenue
Methodist Professional Center
1801 North Senate Avenue
(317) 929-3580

Methodist Hospital Breast Cancer
Screening Program
(317) 929-5000

Eagle Highlands Radiologic Services
6920 Parkdale Place
Suite 111
(317) 291-4411

Lakeview Radiologic Services
9002 North Meridian Street
Suite 110
(317) 844-6944

BROWNSBURG

Brownsburg Radiologic Services
1375 North Green Street
Suite 200
(317) 852-3222



COLUMBUS

(Radiation oncology only)
Bartholomew County Hospital
2400 East Seventeenth Street
(812) 376-5361

CRAWFORDSVILLE

Culver Union Hospital
1710 Lafayette Road
(317) 364-3146

GREENSBURG

Decatur County Memorial Hospital
720 North Lincoln Street
(812) 663-1156

KOKOMO

(Radiation oncology only)
Howard Community Hospital
3500 South Lafountain Street
(317) 453-8189

TERRE HAUTE

(Radiation oncology only)
Union Hospital
1606 North Seventh Street
(812) 238-7504



RADIOLOGIC SPECIALISTS OF INDIANA, INC.

All Physicians Board Certified.

CLINICAL & ANATOMIC PATHOLOGY

The Medical Laboratory

of Drs. Thornton-Haymond-Costin-Buehl-Bolinger-Warner-McGovern-McClure-Hooker-Winkler
5940 West Raymond Street • Indianapolis, Indiana 46241

CHEMISTRY

MICROBIOLOGY

HEMATOLOGY

TOXICOLOGY

CYTOLOGY

HISTOLOGY

CUSTOMER SERVICE



Courier Service

24 hr. Pathology
Consultation

Assignment Accepted:
Medicare/Medicaid

BC/BS VIP and PC/USA,
Preferred Care, Prucare

18 Convenient Branch
Locations

CENTRAL TESTING FACILITY: 5940 W. Raymond St., Indianapolis, IN 46241

Phone: 317/248-2448

"Here Today To Serve You Tomorrow."

DOCTORS

This space is available.

For rates, write or call

INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

PULMONARY DISEASE

RESPIRATORY CONSULTANTS OF INDIANA

DAVID B. COOK, M.D., FCCP
CHRIS C. NAUM, M.D.

MICHAEL R. NIEMEIER, M.D., FCCP
THOMAS Y. SULLIVAN, M.D.
JOHN A. WARDEN, M.D., FCCP

ROBERT W. WELLER, M.D., FCCP
PATRICK E. WRIGHT, M.D., FCCP

Pulmonary Disease

Lung and lung-heart transplantation
Laser Bronchoscopy
Intra-bronchial radiation therapy
Trans-tracheal oxygen therapy
Complete rest and exercise
physiologic testing

Critical Care

Physicians ABIM certified in
critical care 24 hours/day
State-of-the-art eighty bed
intensive care facility

Hyperbaric Medicine

Diagnostic assessment
of local oxygen delivery
Treatment of disorders of
regional O₂ delivery and
utilization

Sleep Disorders

Clinical polysomnographer
Full-service polysomnography
laboratory

1801 N. SENATE BLVD., SUITE 400, INDIANAPOLIS, IN 46202 • OFFICE (317) 929-5820 • FAX (317) 929-3916
6920 PARKDALE PLACE, SUITE 215 • INDIANAPOLIS, IN 46254 • OFFICE (317) 328-6635 • FAX (317) 328-6640
GREENSBURG (812) 653-5533 • LEBANON (317) 873-2103 • RUSHVILLE (317) 932-4111 • TERRE HAUTE (812) 232-0564
AFTER HOURS: ANSWERING SERVICE (317) 926-3466 OR 1-800-772-7788

1-800-321-LUNG • MONDAY - FRIDAY 8:30 A.M. - 4:30 P.M.

ALCOHOLISM TREATMENT

Eugene G. Roach, M.D.
Executive/Medical Director



Anderson Center

of Saint John's
2210 Jackson Street
Anderson, Indiana 46016

1-800-435-9143 or (317) 646-8383

- Comprehensive Alcohol and Drug Treatment
- Separate Programs for Adolescents and Adults
- Free Assessment and Intervention

DOCTORS

This space is available.

For rates, write or call

INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

■physicians' directory

INTERNAL MEDICINE

NEPHROLOGY & INTERNAL MEDICINE, INC.

Thomas W. Alley, M.D., FACP
 George W. Apple, M.D.
 Richard B. Bell, M.D.
 Charles B. Crite, M.D.
 William H. Dick, M.D., FACP
 Theodore F. Hegeman, M.D.
 Douglas F. Linstone, M.D.
 Wendy L. Kridig, M.D.
 LeRoy H. King, Jr., M.D., FACP
 Mary A. Marquis, M.D.
 Tim E. Taber, M.D.

1801 N. Senate Blvd., Suite 355
 Indianapolis 46202
 Tel: 317-924-8425

By Physician Referral

Clinical: Nephrology, Hemodialysis, Peritoneal Dialysis, Renal Transplantation, Metabolic Kidney Stone Disease, Hypertension, Fluid and Electrolyte Imbalance, Critical Care

HEMODIALYSIS

CHRONIC MAINTENANCE OUTPATIENT HEMODIALYSIS

DIALYSIS INSTITUTE OF ANDERSON

2629 Nichol Avenue
 Anderson, Indiana 46011
 317-649-0772

DIALYSIS INSTITUTE OF BEECH GROVE

3834 South Emerson Avenue
 Indianapolis, Indiana 46203
 317-787-3171

For further information contact NEPHROLOGY & INTERNAL MEDICINE, INC.

1801 N. Senate Blvd., Suite #355
 Indianapolis, Indiana 46202
 317-924-8425

Outpatient renal consultation may be scheduled at any location.

HAND SURGERY

JOHN C. KLEIN, M.D.

Specializing in the diagnosis and treatment of hand, wrist, and forearm disorders.

2727 N. Pennsylvania St
 Indianapolis, IN 46205

317-925-1665
 Answered 24 hours

Diplomate American Board of Orthopedic Surgery
 with certificate of added qualifications in surgery of the hand.

DOCTORS – *This space is available.*

For rates, write or call INDIANA MEDICINE,
 322 Canal Walk, Indianapolis, IN 46202-3252,
 (317) 261-2060 or 1-800-257-ISMA.

DERMATOPATHOLOGY

DERMATOPATHOLOGY LABORATORY

Larry J. Buckel, M.D.
Robert M. Hurwitz, M.D.

Howard R. Gray, M.D.
William B. Moores, M.D.



Diplomates of the American Boards
of
Dermatology and Dermatopathology

Specializing in
Inflammatory Skin Diseases
and
Neoplasms of the Skin

9202 North Meridian Street
Suite 215

Approved for and Accept
Medicare and Medicaid
Assignment

Indianapolis, Ind. 46260
(317) 843-2204

UPS Mailers and Courier Service Available

PSYCHIATRY

Eugene G. Roach, M.D.
Executive/Medical Director



Anderson Center

of Saint John's
2210 Jackson Street
Anderson, Indiana 46016

1-800-435-9143 or (317) 646-8114

- Comprehensive Psychiatric Treatment
- Separate Programs for Adolescents, Adults and Older Adults
- Program for Dual Diagnosis

NEUROLOGY

Shirley M. Mueller, M.D.

General Neurology

*Practice Dedicated Toward Problems Associated With
Numbness-Weakness-Dizziness And Pain Including Headache*

Testing Available

317-871-6000

Indianapolis

North: St. Vincent's Professional Bldg. #726

South: Community South Professional Bldg., Suite M

PERIPHERAL VASCULAR SURGERY



VASCULAR SURGERY, P.C.

Vascular
Diagnostics
— Mobile
— Non-invasive
— Testing™

Austin L. Gardner, M.D.
Malcolm B. Herring, M.D.
Daniel R. LeGrand, M.D.
David L. Madison, M.D.
Spencer F. Goodson, M.D.
Sajjad M. Hussain, M.D.

St. Vincent Professional Building
8402 Harcourt Road
Suite 613
Indianapolis, Indiana 46260
Telephone (317) 871-6400
TOLL FREE (800) 662-5367

Carmel Medical Center
13450 North Meridian Street
Suite 160
Carmel, Indiana 46032
Telephone (317) 573-7040
TOLL FREE (800) 446-0298



The Vascular Lab

NONINVASIVE VASCULAR TESTING

The vascular lab offers a full spectrum of diagnostic vascular testing services, including the new addition of color computed sonography, supported by the entire team of:

John F. Ansbro, M.D. • Alan T. Marty, M.D. • H. Dan Adams, M.D.
Richard A. Murrell, M.D. • Daniel B. Daniels, M.D. • Jay Tuna, M.D.

Cardiovascular Surgery Inc.

350 West Columbia
Suite 350
Evansville, Indiana 47710
812-423-2395

■ physicians' directory

ASTHMA & ALLERGY

FRANK WU, M.D.

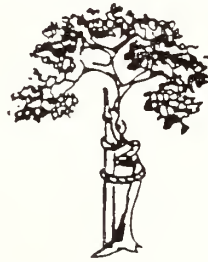


DIPLOMATE,
AMERICAN BOARD
OF ALLERGY &
IMMUNOLOGY

St. Vincent Professional Building
8402 Harcourt Road, Suite 606
Indianapolis, Indiana 46260
(317) 872-4213

ORTHOPAEDIC SURGERY

JAMES L. KAISER, M.D.



- ORTHOPAEDIC SURGERY
- FRACTURES
- BACK SURGERY
- FOOT SURGERY
- ARTHROSCOPIC SURGERY

Certified American Board
Of Orthopaedic Surgery

5626 East 16th Street
Indianapolis, IN 46218

(317) 352-0176
OFFICE ANSWERS DAY & NIGHT

5626 E 16
82nd & Shadeland
If No Answer Call

352-0176
352-0176
543-6089

ONCOLOGY



Oncology Associates

Michael A. Cross, M.D.
Board Certified, Radiology (Therapeutic)

John R. Pancoast, M.D.
Board Certified, Internal Medicine
and Medical Oncology/Hematology

John F. Sacco, M.D.
Board Certified, Internal Medicine
and Radiology (Therapeutic)

Offering comprehensive cancer care, including:

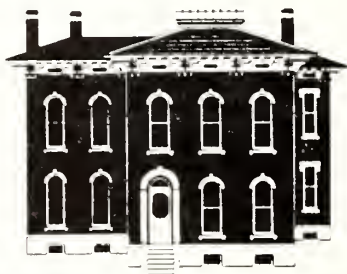
- Cancer Detection
- Chemotherapy
- Radiation Therapy (Linear Accelerator)
- Biologic Therapy
- Education and Support Services
- Hospital, Home and Hospice Care

Dearborn County Hospital Professional Building
606 Wilson Creek Road, Suite 130
Lawrenceburg, Indiana 47025
(812) 537-1911

Oncology Associates' 16 physician members have additional offices in Cincinnati, Montgomery and Middletown, Ohio; and Crestview Hills, Kentucky. The practice offers outpatient care and clinics in 11 hospitals throughout the Tri-State area.

ONCOLOGY — HEMATOLOGY

INDIANA ONCOLOGY HEMATOLOGY CONSULTANTS



1-800-ONC-HEME
1-800-662-4363

Central: 317-927-5770
St. Francis: 317-783-8509

ADULT ONCOLOGY HEMATOLOGY — CENTRAL OFFICE

1828 N. Illinois Street Indianapolis, IN 46202 927-5770

Laurence H. Bates, M.D.

Gregory W. Smith, M.D.

William M. Dugan, Jr., M.D.

William H. Bond, M.D.

Redmond P. Hogan, III, M.D.

PEDIATRIC ONCOLOGY HEMATOLOGY — CENTRAL OFFICE

1828 N. Illinois Street Indianapolis, IN 46202 927-5770

Arthur J. Provisor, M.D.

Deborah S. Provisor, M.D.

ADULT ONCOLOGY HEMATOLOGY — ST. FRANCIS OFFICE

1600 Albany — Medical Clinic Bldg. Beech Grove, IN 46107 783-8509

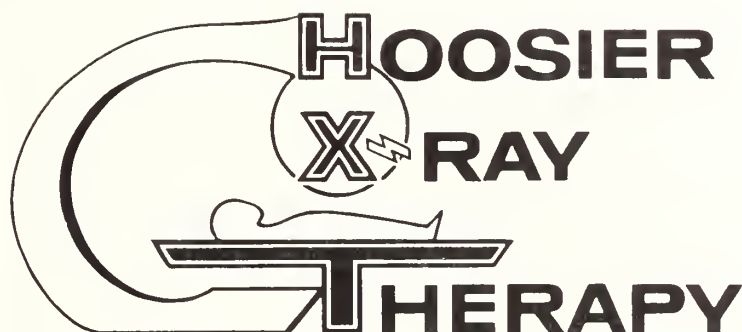
Redmond P. Hogan, III, M.D.

Randall C. Trowbridge, M.D.

Gregory W. Smith, M.D.

*Central Office Located in the Byram Gates Middleton House
Listed on the National Register of Historic Places*

RADIATION ONCOLOGY



Physicians:
ROGER ROBISON
TAE CHUNG
DAVID BELL

Radiation Oncology Services for Southwest Indiana

VINCENNES
Good Samaritan Hospital
(812) 885-3939

TERRE HAUTE
Regional Hospital
(812) 237-9326

ROGER ROBISON, M.D., F.A.C.P.
M.D. Anderson, 1980
Certified: Radiation
Oncology
Medical Oncology

TAE CHUNG, M.D.
Chicago Hines, V.A., 1976
Certified: Radiation
Oncology

DAVID BELL, M.D., Ph.D.
M.D. Anderson, 1981
Certified: Radiation
Oncology

RADIATION ONCOLOGY

TRI-STATE RADIATION ONCOLOGY

Evansville Cancer Center
Evansville, Indiana
(812) 474-1110



Welborn Cancer Center
Evansville, Indiana
(812) 426-8373

AL KORBA, M.D.; ALY RAZEK, M.D.
SHANNON LAMB, M.D.; PRAMOD V. PRABHU, M.D.

★ ★ ★ ★ ★

Tri-County Cancer Care Center
Jasper, Indiana
(812) 482-2212
DEV DAS SHETH, M.D.

Tri-County Cancer Care Center
Princeton, Indiana
(812) 386-6663
MOISES DOMINGO, M.D.

★ ★ ★ ★ ★

Olney Cancer Center
Olney, Illinois
(618) 392-3050
MOISES DOMINGO, M.D.

Harrisburg Oncology Associates
Harrisburg, Illinois
(618) 252-5126
MANJU GUPTA, M.D.

★ ★ ★ ★ ★

Radiation Oncology
Owensboro, Kentucky
(502) 926-7228
TRISTAN BRIONES, M.D.

Henderson Cancer Center
Henderson, Kentucky
(502) 827-0255
PRAMOD V. PRABHU, M.D.

★ ★ ★ ★ ★

In Indiana 1-800-843-7117 • Out of Indiana 1-800-331-9294
24-hour answering service (812) 476-1367

TRANSPLANTATION

*Transplantation offers patients
with end-stage organ disease their only
opportunity for true rehabilitation...*

Methodist Transplant Center
24-hour referral: 800 772-7788



The Difference is Experience

P.O. Box 1367
1701 N. Senate Blvd.
Indianapolis, Indiana 46206

Heart Transplantation

Surgical Director: Harold Halbrook, M.D.

Surgeons: John Fehrenbacher, M.D.,
Daniel Beckman, M.D., David Hormuth, M.D.

Program Cardiologist: Douglas Pitts, M.D.

Kidney Transplantation Pancreas Transplantation

Surgical Director: Brian Haag, M.D.

Surgeons: Larry Stevens, M.D.,
Dale A. Rouch, M.D.

Program Nephrologist: Charles Carter, M.D.

Lung Transplantation

Surgical Director: Harold Halbrook, M.D.

Surgeons: John Fehrenbacher, M.D.,
Daniel Beckman, M.D., David Hormuth, M.D.

Program Pulmonologist:

Michael Niemeier, M.D.

Liver Transplantation

Surgical Director: Dale A. Rouch, M.D.

Surgeons: Larry Stevens, M.D.,
Brian Haag, M.D.

Program Pediatric Gastroenterologist:

Susan Maisel, M.D.

Program Hepatologist: Stephen C. Pappas, M.D.

Bone Marrow Transplantation

Co-Director: Luke Akard, M.D.

Co-Director: Jan Jansen, M.D., Ph.D.

Corneal Transplantation

Surgical Director: Stephen Johnson, M.D.

Tissue/Bone Bank

Surgical Director: David A. Fisher, M.D.

ORTHOPAEDIC SURGERY

PERFORMANCE



IN A HIGH-PERFORMANCE SPORTS CAR, THE SPOKES ARE AN INTEGRAL PART OF THE ENGINEERING. EACH INDIVIDUAL SPOKE IS STRONG, YET IT'S THE WAY THEY'RE INTERWOVEN THAT GIVES EXCEPTIONAL STRENGTH AND BALANCE.

THAT'S THE WAY IT IS AT ORTHOPAEDICS INDIANAPOLIS. EACH OF OUR 19 PHYSICIANS HAS UNIQUE INDIVIDUAL STRENGTHS AND SKILLS. THE ABILITY TO DRAW ON EACH OTHER'S SPECIAL EXPERTISE STRENGTHENS OUR CAPABILITIES AND ENHANCES OUR PERFORMANCE.

AS THE EXCLUSIVE PROVIDER OF RAPID AND EXTENSIVE ORTHOPAEDIC RECONSTRUCTIVE SURGERY FOR METHODIST HOSPITAL'S EMERGENCY MEDICINE AND TRAUMA CENTER, WE TREAT OVER 1,000 TRAUMA CASES A YEAR PROVIDING US WITH EXPERIENCE IN EVERY FACET OF ORTHOPAEDIC CARE. THAT'S WHY DOCTORS FROM ALL 50 STATES AND 11 FOREIGN COUNTRIES HAVE SOUGHT OUR HELP TREATING THEIR MOST COMPLEX CASES.

DONALD S. BLACKWELL, M.D.
F.R. BRUECKMANN, M.D., F.A.C.S.
ANTHONY R. LASICH, M.D.
WILLIAM O. IRVINE, M.D.
JOSEPH C. RANDOLPH, M.D.
DONALD E. RUSSELL, M.D.
MARK R. STEVENS, M.D.
TERRY R. TRAMMELL, M.D.
ANDREW J. VICAR, M.D.
VINCENT L. FRAGOMENI, M.D.
JOHN K. SCHNEIDER, M.D.
JOSEPH R. BAELE, M.D.
SANFORD S. KUNKEL, M.D.
DAVID A. FISHER, M.D.
D. KEVIN SCHEID, M.D.
MICHAEL F. COSCIA, M.D.
HENRY G. STEIN, M.D., F.A.C.S.
ORTHOPAEDIC SURGEONS
ROBERT C. GREGORI, M.D.
PHYSICAL MEDICINE & REHABILITATION

JOINT RECONSTRUCTION
TRAUMA
FRACTURE CARE
SPORTS MEDICINE
SCOLIOSIS
SPINAL SURGERY
SHOULDER SURGERY
HAND SURGERY
FOOT SURGERY
ARTHROSCOPIC SURGERY
PEDIATRIC ORTHOPAEDICS
ADULT ORTHOPAEDICS
ILIZAROV LIMB LENGTHENING
& DEFORMITY CORRECTION



**ORTHOPAEDICS
INDIANAPOLIS**

INDIANAPOLIS • DANVILLE
GREENCASTLE • SPEEDWAY
ZIONSVILLE
317-923-5352
1-800-223-3381

ORTHOPAEDICS & SPORTS MEDICINE

Hoosier Orthopaedics & Sports Medicine, P.C.

The Foot Program staff medically manages
common foot problems such as:

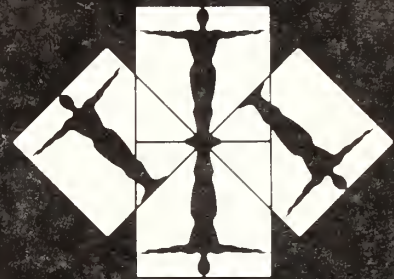
Ingrown Toenails
Mortons Neuroma
Hammer Toes
Bunions
Bunionette
Foot Strain
Soft Corns
Corns
Calluses
Planter Warts

Special emphasis on diabetic and rheumatoid
arthritis foot problems. The services of a
Pedicurist are available by appointment.

Office Answers Day and Night

13450 North Meridian Street, Suite 355, Carmel, Indiana 46032
(317) 575-2705

8330 Naab Road, Suite 234, Indianapolis, Indiana 46260
(317) 870-7075



Robert M. Palmer, M.D.

Frank B. Throop, M.D.

Robert T. Clayton, M.D.

Robert E. Cravens, M.D.

John E. Garber, M.D.

Thomas F. Trainer, M.D.



COMPREHENSIVE REHABILITATION

We're Working to Make Life Better

At Kokomo Rehabilitation Hospital, we're committed to only one specialized field – rehabilitation medicine.

This central focus means your patients receive the therapy and care needed to restore their lives to the fullest extent possible.



**Kokomo
Rehabilitation
Hospital**

Our newly opened, 60 bed hospital features sophisticated high-tech equipment, a total barrier-free environment and highly trained therapists.

Give us a try. Your patients and you will be pleased with the results.

– William J. Lester, MD.
Medical Director

Bringing the Quality Back to Life for Patients Affected by:

Stroke • Traumatic Brain Injury • Spinal Cord Injury • Amputation • Orthopedic Disorders • Neurological Disorders • Arthritis • Back and Neck Injuries • Chronic Pain • Multiple Trauma • Return to Work
• Carpal Tunnel Syndrome and other Cumulative Trauma Disorders

829 Dixon Road • Kokomo, Indiana 46901
General Hospital Information
(317) 452-6700

For Referral or Admission Information
1-800-886-LIFE

A Continental Medical Systems Facility

DOCTORS

This space is available.

For rates, write or call

INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

MULTI-SPECIALTY GROUP PRACTICE

Addictionology
Allergy
Cardiovascular Diseases
Dermatology
Endocrinology
Family Practice
Gastroenterology
Gynecology
Hematology-Oncology
Internal Medicine
Neurology
Nephrology
Nuclear Medicine
Obstetrics
Ophthalmology
Orthopedics
Otolaryngology
Pediatrics
Psychiatry
Pulmonary Medicine
Rheumatology
Surgery
Urology



**Welborn
Clinic**

421 Chestnut Street
Evansville, Indiana 47713
(812)426-9440

Toll-free in Indiana:
1-800-521-0269

Westside Family Practice Ctr.
(812)429-1818

Welborn Clinic East
(812)474-7123

Welborn Clinic Highland
(812)426-9565

In Newburgh:
Welborn Clinic Newburgh
(812)853-7391

In Reo:
Reo Family Practice Center
(812)649-5061

**The AMA
Hospital Medical Staff Section
Nineteenth Assembly Meeting
June 18-22, 1992
Chicago Marriott Hotel
Chicago, Illinois**

**Highlights of the Annual Meeting will include
an educational program on:**

Option 1: Medical Staff Bylaws: Principles and Practices

Medical Staff leaders will receive a practical overview of the purpose, function and organization of medical staff bylaws, including discussion of selected provisions regarding the Health Care Quality Improvement Act, provision for policy statements, and other relevant issues. Participants will have the opportunity to participate in discussion, and ask questions pertinent to your own institution. Speakers will include legal experts from the American Medical Association and from private medical staff attorney firms.

Option 2: Outcomes Management: A Medical Staff Issue

Medical staffs are confronted with increasing pressures to respond to patient care data that is being collected for outcomes measure, quality assurance, utilization review and for other hospital purposes in the interest of quality and efficiency. Medical staff leaders will be provided with a perspective in data collection and outcomes management, and will hear how to focus data collection for successful and appropriate application in the interest of improved patient care. Speakers will be physician experts in the field of outcomes management and total quality improvement.

For Information Contact:

Department of Hospital Medical Staff Services
American Medical Association
515 North State Street
Chicago, Illinois 60610
Phone (312) 464-4754 or 464-4761



H M S S

Indiana University

The Indiana University School of Medicine will sponsor these courses:

May 28-31- Rejuvenation of Face 1992, University Place Conference Center, Indianapolis.

June 11-13- Fourth International Symposium on Neuronal Ceroid-Lipofuscinoses, Hamburg, Germany.

June 19 - Indiana Residents and Alumni Day - Ophthalmology, Indianapolis site to be announced.

July 6-15 - 77th Annual Academy and Histopathology of the Head and Neck and Temporal Bone, Indiana University Medical Center, Indianapolis.

July 31-Aug. 1 - Laparoscopy and Its Complications, University Place Conference Center, Indianapolis.

For more information, call (317) 274-8353.

Ohio State University

The Ohio State University College of Medicine will sponsor these CME courses:

June 8-10 - Facial Reconstructive Surgery, Great Southern Hotel, Columbus, Ohio.

June 11-12- Cardiology Update, Hyatt on Capitol Square, Columbus, Ohio.

Sept. 19 - Annual Cancer Update, Rhodes Hall Auditorium, The Ohio State University Hospitals.

Sept. 25-26- New Hypertensive Agents, University Ramada Inn, Columbus, Ohio.

Sept. 25-27- Dermatopathology, Columbus Marriott North, Columbus, Ohio.

For more information, call 1-800-492-4445.

University of Wisconsin

The University of Wisconsin School of Medicine will sponsor the Second Biennial Phonosurgery Symposium July 9 through 11 at the University of Wisconsin Hospital and Clinics in Madison.

The course is recommended for otolaryngologists, speech pathologists, scientists and others interested in surgical management of voice problems.

For more information, call Cathy Means at (608) 263-6637.

University of Michigan

The University of Michigan Medical School will sponsor the Sixth Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management July 12 through 15 at the Grand Traverse

Resort Village in Grand Traverse Resort, Mich.

This course will include presentations on the newest developments in breast imaging and diagnostic techniques including mammography and fine-needle aspiration biopsy. Small group discussions of various diagnostic, management and technical issues will be included.

For more information, call Edwina Borde, (313) 763-1400.

Washington University

The Washington University School of Medicine in St. Louis will sponsor these CME courses:

June 4-7 - Advances in Aesthetic & Reconstructive Breast Surgery, The Ritz-Carlton Hotel, St. Louis.

June 11-13- Cornea and Contact Lens Conference, The Ritz-Carlton Hotel, St. Louis.

June 26-28- Frontiers in Endourology: Laparoscopy Nephrectomy and Beyond, Washington University Medical Center, St. Louis.

Aug. 6-8 - Clinical Allergy for the Practicing Physician, The Ritz-Carlton Hotel, St. Louis.

For more information, call 1-800-325-9862. ■

Sponsors of CME classes may submit information for publication in the CME calendar. The deadline for submitting CME news is two months before the month of publication, e.g. May 10 for the July issue. News should be sent to Tina Sims, INDIANA MEDICINE, 322 Canal Walk, Indianapolis, IN 46202-3252.

■ what's new

The Message On Hold Network has developed an on hold system for physicians that allows them to control what their callers hear through informative messages interspersed with music. The network does not use the radio or infringe on ASCAP and BMI licensing, the two major music licensing agencies. For more information, call (317) 299-3130.

Lea & Febiger has published the following editions: *Doppler Echocardiography*, third edition; *Levitt & Tapley's Technological Basis of Radiation Therapy: Practical Clinical Application*, second edition; *Rapid Analysis of Electrocardiograms: A Self-Study Course*, second edition; *Progress in Cardiology 5/1*; *Handbook of Federal Drug Law*, second edition; and *Differential Diagnosis in Dermatopathology I*, second edition.

To order any of these books on a 30-day approval, contact Lea & Febiger, 200 Chester Field Parkway, Malvern, PA 19355-9725, 1-800-638-0672.

Medical Software Products has released its *Medical Software Catalog*, a directory of more than 100 specialized software products for physicians and health professionals. The catalog includes software for accredited continuing

medical education, diagnostic assistance, drug interactions, prescription writing, ICD-9 and CPT coding, medical records and office management. For a free catalog, write Medical Software Products, 591 W. Hamilton Ave., Suite 205, Campbell, CA 95008.

Pfizer Inc. has begun shipping ZithromaxTM, an azalide antibiotic, to pharmacies. Zithromax is taken once-daily for five days for indicated mild to moderate respiratory tract and skin infections.

The Upjohn Co. has received approval from the U.S. Food and Drug Administration to market Glyne PresTab tablets used to treat non-insulin-dependent diabetes. Physicians will need to titrate the dosage of the tablets with patients' blood sugar levels.

Abbott Laboratories has introduced OmnifloxTM tablets, a new oral antibiotic for a broad range of bacterial infections. A member of the quinolone class of antibiotics, Omniflox is active in vitro against certain Gram-negative and Gram-positive bacteria, as well as some atypical pathogens and anaerobes. It can be used to treat certain infections of the lower respiratory tract, uri-

nary tract, skin and skin structures and bacterial prostatitis.

American Hospital Publishing has released *Bridging the Communication Gap with the Elderly: Practical Strategies for Caregivers*, a guide to communicating with elderly patients and clients. The book offers solutions to communication barriers such as hearing and sight loss, loss of speech and memory, paranoia and depression. The book is recommended for physicians, nurses, nurse assistants, home health aides, social workers and physical therapists. To order, write American Hospital Publishing, P.O. Box 92683, Chicago, IL 60675-2683. The book is \$25.95, plus \$6.95 for shipping and handling, or \$19.95 for AHA members, plus \$4.95.

The American Association of Blood Banks has published the 14th edition of *Standards for Blood Banks and Transfusion Services*. Topics include general policies, plasmapheresis, cytappheresis, compatibility testing, issuing blood for transfusion, administration of Rh immune globulin and requirements for record keeping and labeling. It is available for \$25 from the association's Sales Office, 1117 N. 19th St., Suite 600, Arlington, VA 22209. □



We've mastered the delicate art of getting your money faster and at less expense. Call us.

(317) 643-2588

pbs : professional
billing service
of Central Indiana : inc.

Auto Buyers Network

The #1 priority at Auto Buyers Network is to provide you with an easy, timely, and affordable way to purchase your next new or used car, truck or van. Tell us the make and model vehicle that you prefer and **we** do the legwork. No more disputing with salesmen, wondering and worrying if you're getting a "good deal." We can even arrange leasing or financing utilizing the best rates available from several participating lenders.

▲ Personalized Service Statewide ▲

Auto Buyers Network

Bill Prewitt, ISMA Consultant

40 West 40th Street, Indianapolis, IN 46208

317/ 921-1537 or 800/736-0172

■ obituaries

Frank A. Benchik, M.D.

Dr. Benchik, 71, a Munster family practitioner, died Oct. 28, 1991.

He was a 1945 graduate of the St. Louis University School of Medicine and served as a captain in the U.S. Army at Fitzsimmons General Hospital in Denver.

Dr. Benchik was a diplomate of the American Board of Family Practice and a member of the American Academy of Family Practice and the Occupational Medical Society. He was a past president of the St. Catherine Hospital medical staff.

Robert G. Cook, M.D.

Dr. Cook, 78, a retired Bluffton otolaryngologist, died Jan. 7 at Meadowvale Care Center in Bluffton.

He was a 1940 graduate of the University of Cincinnati College of Medicine and an Army Medical Corps veteran of World War II.

Dr. Cook was affiliated with the Caylor-Nickel Clinic. He retired in 1978.

Edward R. Cotter, M.D.

Dr. Cotter, 80, a retired Hammond general surgeon, died Feb. 9.

He was a 1936 graduate of the Loyola University Stritch School of Medicine and served as an Army physician in World War II.

Dr. Cotter opened his private practice in 1938 at the Indiana Harbor Clinic with his father, Dr. Thomas Cotter. He was a life member of the American Academy of Family Physicians.

Isadore E. Friedman, M.D.

Dr. Friedman, 77, a Munster ophthalmologist, died Jan. 8 at Community Hospital in Munster.

He was a 1939 graduate of the University of Illinois College of Medicine and an Army veteran of World War II.

Dr. Friedman had been on the medical staffs at St. Margaret Hospital in Hammond and Our Lady of Mercy Hospital in Dyer.

Robert A. Hedgcock, M.D.

Dr. Hedgcock, 87, a Frankfort family practitioner, died Jan. 5 at his home.

He was a 1930 graduate of the Indiana University School of Medicine.

Dr. Hedgcock was semi-retired, but still practiced medicine. He was a member of several civic groups.

K. William Koss, M.D.

Dr. Koss, 64, a Muncie family practitioner, died Feb. 15 at his home.

He was a 1956 graduate of the Indiana University School of Medicine and a Navy veteran of World War II.

Dr. Koss practiced general medicine, allergy and immunology in Muncie from 1956 until his death. He was Delaware County health officer for 12 years. He was a diplomate of the American Academy of Family Practice, a fellow of the American Academy of Allergy and Immunology and a member of the American Association of Allergy and Immunology.

Glenn C. Lord, M.D.

Dr. Lord, 87, a founder of the Indiana Council on Alcoholism and the St. Vincent Stress Center, died Feb. 27 at St. Vincent Hospital in Indianapolis.

He was a 1931 graduate of the Indiana University School of Medicine.

Dr. Lord retired in 1986, after 50 years in practice. He was attending physician at the Indiana School for the Deaf more than 25 years. He was a past president of the St. Vincent Hospital staff and

a former member of the Board of Trustees of the St. Vincent Hospital Foundation.

Jashbhai N. Patel, M.D.

Dr. Patel, 64, a retired Fort Wayne general surgeon, died Jan. 14 at St. Joseph Medical Center in Fort Wayne.

He was a 1953 graduate of the B.J. Medical College, Gujarat University, in Ahmedabad, India.

Dr. Patel was a member of the Veterans Administration Medical Center from 1972 to 1980 and in private practice from 1980 to 1985. He later worked at the Fort Wayne Developmental Center. Before coming to Fort Wayne, he practiced at various hospitals in India and England.

Hubert J. Ryan, M.D.

Dr. Ryan, 92, a retired pediatrician in Merrillville and Gary, died Feb. 21 at his home in New Smyrna Beach, Fla.

He was a 1927 graduate of the Loyola University Medical School.

Dr. Ryan retired in 1977 after more than 50 years as a pediatrician. He was on the staffs of Gary Mercy and Methodist hospitals and the first pediatrician to serve on the Gary Health Board.

Herbert A. Schiller, M.D.

Dr. Schiller, 83, a retired South Bend obstetrician/gynecologist, died March 1 at his winter residence in Phoenix, Ariz.

He was a 1935 graduate of the University of Illinois College of Medicine and an Army Medical Corps veteran of World War II.

Dr. Schiller delivered more than 9,000 babies during his career, which began in 1939 and continued until his retirement in 1984. He served as president of the St. Joseph County Medical Society and of the South Bend

Board of Health and was a founding member of Family Planning, now known as Planned Parenthood. He was chairman of the South Bend Citizens' Committee for Fluoridation for 10 years. He was the former chief of staff of obstetrics and gynecology at Memorial Hospital and the former St.

Joseph's Hospital.

Morris E. Thomas, M.D.

Dr. Thomas, 80, died Jan. 18 at New Smyrna Beach, Fla. He had a private internal medicine practice in Indianapolis from 1946 to 1986.

He was a 1938 graduate of the

Indiana University School of Medicine and served in the Army Medical Corps during World War II.

Dr. Thomas had been a member of the admission committee of the I.U. School of Medicine and chairman of the Indianapolis Medical Society. □

**Over 650 cases
of oral cancer
will be detected
in Indiana
this year.**

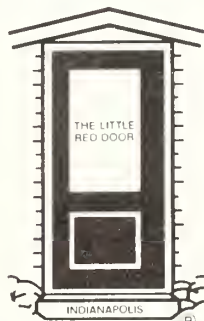


If you are...

- * a smoker
- * a heavy drinker
- * a smokeless tobacco user at any age

...you should be examined.

Little Red Door Cancer Agency



offers FREE screening exams.

IU School of Dentistry

Call today for an appointment

317/925-5595

Dr. Patricia A. Keener, an Indianapolis pediatrician, was named a "Hoosier Hero" by U.S. Sen. Dan Coats for her contributions to reducing infant mortality in Marion County; Dr. Keener is chief of pediatrics at Wishard Memorial Hospital, medical director for the Wishard Community Health Centers and medical director of the Indianapolis Campaign for Healthy Babies.

Dr. William H. Beeson of Indianapolis was program chairman for the Facial Plastic Section of the annual scientific meeting of the American Academy of Cosmetic Surgery in Los Angeles; he also spoke on chemical face peeling and face lift surgery during the master's panel for cosmetic surgery of the head and neck.

Dr. Richard T. Miyamoto, an Indianapolis otolaryngologist, was an invited speaker at the First International Conference on Acoustic Neuroma in Copenhagen, Denmark, and at the National Institutes of Health Consensus Development Conference on Acoustic Neuroma.

Dr. Donald A. Rothbaum of Northside Cardiology in Indianapolis is a slated speaker at several meetings; he discussed "Excimer Laser Coronary Angioplasty and Interventional Stent Implantation" at Cedars-Sinai Medical Center in Los Angeles and is scheduled to speak on "Use of Laser with PTCA" at the Israel Heart National Heart to Heart Association Annual Meeting in Tel Aviv, Israel, and on "The Use of Excimer Laser" at the International Conference in Rome.

Dr. Thomas J. Linnemeier of Northside Cardiology in Indianapolis spoke on excimer laser angioplasty at the Arizona Heart Institute's International Congress V: Strategies in Endovascular Interventions in Scottsdale and will

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

January 1992

Archangel, Cesar S., Jeffersonville
Blair, William E., LaPorte
Campbell, Betty J., Terre Haute
Cook, Ian H., Fort Wayne
Crawford, John N., Fort Wayne
Daniels, Daniel Bell, Evansville
Edlund, James W., Fort Wayne
Ferree, Harry L., Indianapolis
Fischer, Thomas J., Indianapolis
Fishman, Peggy Hartis, New Albany
Haynes, John T., Indianapolis
Kintanar, Thomas A., Fort Wayne
Kubley, Jon B., Plymouth
Munoz, Jose C., Fort Wayne
Nesbitt, William Alva, Connersville
Nicholas, Thomas D., Rockville
Patel, Danyanti R., Anderson
Rettig, Arthur C., Indianapolis
Roch, L. Marshall, Muncie
Rogers, Susan, J., Marion
Singco, Bienvenido O., Greenfield
Stoltzfus, Virgil De Lee, Valparaiso

February 1992

Bastnagel, William F., Indianapolis
Black, Kenneth A., Portage
Bueter, Anne P., Carmel
Clark, Michael A., Indianapolis
Fondak, Alexander A., Kokomo
Harwood, Raymond M., Indianapolis
Kerner, Donald J., Indianapolis
Kishan, Anita, Warsaw
Lee, Randall A., Martinsville
Lee, Shui C., Fort Wayne
McDonald, Joseph D., Evansville
McKinley, Lee, Bloomington
Patel, Jaiminikumar R., Terre Haute
Popp, Beth, Indianapolis
Raflo, Gary T., Indianapolis
Rajmaira, Salil, Upland
Rutt, Carl N., Goshen
Schurz, John Wm., South Bend
Sorak, Katica, Munster
Tomlinson, Gregory C., Fort Wayne
Wentworth, Samuel, Danville

discuss the same topic at the Cardiostim '92 in Nice, France; he presented an abstract on diagnostic intracoronary ultrasound at the American College of Cardiology.

Drs. David A. Fisher and **Sanford S. Kunkel** of Orthopaedics Indianapolis were inducted as fellows of the American Academy of Orthopaedic Surgeons.

Dr. James F. Rold, an Evansville radiologist, is the author of a recently published novel titled "First Degree Love," concerning a Kentucky physician who administers lethal assistance to three patients.

Dr. Richard D. Zeph, an Indianapolis facial plastic and reconstructive surgeon, spoke on open structure rhinoplasty for the non-

Caucasian nose during the Open Structure Rhinoplasty Course in New Orleans.

Dr. Alan Bercovitz, a family practitioner, has moved his office to 8240 Naab Road, Suite 110, Indianapolis.

Dr. Rank O. Dawson, an Indianapolis plastic surgeon, has been certified by the American Board of Plastic Surgery and has become a member of the American Society of Plastic and Reconstructive Surgeons and the Undersea and Hyperbaric Medical Society; he recently discussed the applications of hyperbaric medicine in plastic surgery at the Second Annual Midwest Symposium on Hyperbaric Medicine.

Dr. C. William Hanke, professor of dermatology, pathology

and otolaryngology at the Indiana University Medical Center, was elected president of the American College of Mohs Micrographic Surgery and Cutaneous Oncology at the annual meeting of the college in Scottsdale, Ariz.

Dr. Panayotis Iatridis, assistant dean of the Northwest Center for Medical Education, Indiana University School of Medicine, was elected to the Academy of Athens, Greece; membership in the academy is an honor given to those who have achieved recognition in science, arts and letters and who have published extensively in the Greek and international literature.

Activities and accomplishments of physicians from the Indiana Hand Center in Indianapolis include the following: **Dr. Hill Hastings II** was a faculty member at the annual meeting of the American Academy of Orthopaedic Surgeons in Washington, D.C. **Dr. Thomas J. Fischer** lectured on preventing serious hand injuries in the workplace at the annual Hoosier Safety Council Convention and spoke on digital replantations at a meeting of the Indiana Society of Post Anesthesia Nurses. **Dr. James W. Strickland** was named chairman of the hand surgery department at St. Vincent Hospital. **Dr. Richard S. Idler** was elected to the Hand Society Council of the American Society for Surgery of the Hand.

Dr. Derek J. Sharvelle, medical director of the Lafayette Eye Clinic, spoke on phacoemulsification and no-stitch cataract surgery at the Southern African Society for Cataract and Refractive Surgery Congress in Johannesburg. **Dr. Edmund L. Van Buskirk**, chief of ophthalmology at Lafayette Home Hospital, recently joined Dr. Sharvelle at the Lafayette Eye Center.

Dr. Salil Rajmaira of Marion was named a diplomate of the American Board of Orthopaedic Surgery.

Dr. William K. Newcomb has retired after 50 years as a Royal Center family practitioner.

Dr. Robert Erwin has retired after 32 years as a LaPorte family practitioner.

Dr. David J. Welsh, a Batesville general surgeon, was elected chief of staff at Margaret Mary Community Hospital.

Dr. John P. Smith was named medical director at Parkview Memorial Hospital in Fort Wayne.

Dr. Gerald M. Wohlfeld, a New Albany radiologist, was elected vice president of the South Central Indiana Association of the Handicapped.

Dr. Larry G. Thompson, an anesthesiologist, was named president of the medical staff of Memorial Hospital of South Bend.

Dr. C. Dyke Egnatz, ISMA president and a Schererville family practitioner, was recognized for his services to the Lake Central High School football team and other school athletes since 1961; he received a lifetime pass for two to all Lake Central High School activities.

Dr. Robert M. Ellis, a Madison family practitioner, was elected president of King's Daughters' Hospital medical staff.

Dr. James B. Johnson, a retired Greencastle family practitioner, was named 1991 Putnam County Citizen of the Year; he was recognized for his accomplishments as a physician and for his many volunteer activities.

Dr. Rajan I. Mehta of Bloomington was named a diplomate of the American Board of Allergy and Immunology.

Dr. George H. Rawls, an Indianapolis surgeon, was the key-

note speaker for a National Association for the Advancement of Colored People membership luncheon in Evansville.

Dr. Tom Anderson of Delphi was elected president of the American Heart Association, Carroll County Division.

Dr. Duane A. Hougendobler, a Huntington pediatrician, was elected chief of the medical staff at Huntington Memorial Hospital.

Dr. Barbara R. Sturm of Franklin has been certified by the American Board of Dermatology.

Dr. Kevin R. Burke, a Jeffersonville internist, was named president of the medical staff of Clark Memorial Hospital.

Several abstracts on dobutamine stress echocardiography from the lab of **Dr. Harvey Feigenbaum** of the Krannert Institute of Cardiology in Indianapolis were presented at the American Heart Association's annual scientific sessions. **Dr. Robert W. Burt**, **Dr. David Whang** and **Dr. Patrick Bourdillon** of Krannert also contributed to the abstracts. **Dr. David R. Hathaway** of Krannert was chairman of a session on "Mechanism of Vascular Tone" at the meeting.

Dr. Douglas P. Zipes of the Krannert Institute of Cardiology in Indianapolis gave the Paul Dudley White Lecture at the 24th annual New York Cardiovascular Symposium; his topic was "Contemporary Arrhythmia Care: More Electricity and Less Drugs." He will be scientific program chairman of the InterAmerican Congress of Cardiology, hosted by the American Heart Association May 24 to 27 in Orlando, Fla. **Dr. Zipes** and **Dr. Harvey Feigenbaum** and **Dr. Charles Fisch**, also of Krannert, were contributors to *Braunwald Heart Disease: A Textbook of Cardiovascular Medicine, 4th Edition*. □

■ people

New ISMA members

Adolphus A. Anekwe, M.D., Gary, internal medicine.

Robert W. Ausdenmoore, M.D., Lawrenceburg, allergy and immunology.

Frederick B. Axelrod, M.D., Indianapolis, anatomic/clinical pathology.

Jerry G. Back, M.D., LaPorte, internal medicine.

Anthony S. Blazys, M.D., Chicago, anesthesiology.

Jeffrey W. Bragg, D.O., Marion, family practice.

David W. Brewer, M.D., Evansville, emergency medicine.

Anil Chawla, M.D., Michigan City, internal medicine.

John M. Cherf, M.D., Richmond, orthopaedic surgery.

Krishna R. Chilukuri, M.D., Evansville, family practice.

Wayne A. Christenson, M.D., Goshen, psychiatry.

David L. Clayton, M.D., South Bend, family practice.

John J. Coleman III, M.D., Indianapolis, oncology.

Andrew T. Cooley, M.D., Evansville, psychiatry.

Anna M. Fisher, M.D., New Albany, family practice.

Gene R. Flick, M.D., Evansville, psychiatry.

Karin M. Forshell-Velander, M.D., Merrillville, plastic surgery.

Gustavo E. Galante, M.D., Munster, plastic surgery.

Molly M. Garau, M.D., Indianapolis, family practice.

Stanley S. Givens, M.D., Indianapolis, radiation oncology.

Ayoola K. Gomih, M.D., Gary, urological surgery.

Joe S. Greene, M.D., Decatur, family practice.

Joseph H. Harpole Jr., M.D.,

Evansville, diagnostic radiology.

Michael R. Harrison, M.D., Evansville, cardiovascular diseases.

Worthe S. Holt Jr., M.D., Indianapolis, family practice.

Sajjad M. Hussain, M.D., Indianapolis, vascular surgery.

Bruce C. Inman, M.D., Danville, general surgery.

Russell F. Johnson, M.D., South Bend, radiation oncology.

Gartrell D. King, M.D., East Chicago, internal medicine.

Daniel E. Krach, M.D., Fort Wayne, ophthalmology.

David J. Kraus, M.D., South Bend, radiation oncology.

William J. Lester, M.D., Kokomo, physical medicine and rehabilitation.

Jose A. Mayoral, M.D., Greenwood, child psychiatry.

Kevin E. Miller, M.D., Lafayette, obstetrics and gynecology.

Margaret C. Mumford, M.D., Evansville, obstetrics and gynecology.

Jeffrey P. Myers, M.D., Beech Grove, obstetrics and gynecology.

Steven L. Nelson, M.D., Evansville, psychiatry.

Robert C. Palmer, M.D., Nashville, child psychiatry.

Dean D. Paulsen, M.D., Elwood, obstetrics and gynecology.

Andrea E. Pernell, M.D., Evansville, physical medicine and rehabilitation.

Steven D. Poe, D.O., Marion, emergency medicine.

Edna B. Pretila, M.D., Scottsburg, internal medicine.

Wayne C. Pretila, M.D., Scottsburg, anesthesiology.

Darrell K. Quick, M.D.,

Lafayette, occupational medicine.

Kosaraju Rao, M.D., South Bend, allergy and immunology.

Denise S. Reeves, M.D., Muncie, obstetrics and gynecology.

Michael A. Rhodes, M.D., South Bend, family practice.

Helen G. Robins, M.D., Indianapolis, family practice.

Daniel J. Robinson, M.D., Indianapolis, ophthalmology.

Philip S. Rudman, M.D., Bloomington, diagnostic radiology.

Vance H. Smith, M.D., Munster, general surgery.

Thomas E. Stamps, M.D., Evansville, internal medicine.

Tristan V. Stonger, M.D., Peru, plastic surgery.

Harlan T. Stratton, M.D., Indianapolis, orthopaedic surgery.

Jim D. Swanson, M.D., Lawrenceburg, orthopaedic surgery.

Charles P. Taliercio, M.D., Indianapolis, cardiovascular diseases.

David B. Tribble, M.D., South Bend, family practice.

Mary K. Turner, M.D., Indianapolis, general surgery.

William L. Walling, M.D., Evansville, family practice.

Robert E. Wilkins, M.D., Fort Wayne, family practice.

David W. Zauel, M.D., Danville, ophthalmology.

Residents

Mark S. Floyd, M.D., Greenwood, internal medicine.

James R. Stinebaugh Jr., M.D., Noblesville, cardiovascular diseases.

Deborah S. Wayne, D.O., Henderson, Ky., family practice. □

Indiana Heart Physicians affiliates with Cleveland Clinic

Indiana Heart Physicians and Cleveland Clinic Foundation have announced a collaborative agreement to jointly expand the education and research activities of both organizations. Indiana Heart Physicians is comprised of 16 cardiologists who are affiliated with St. Francis Hospital Center in Beech Grove and are members of the Indianapolis Regional Heart Center at St. Francis.

The Cleveland Clinic Foundation will provide Indiana Heart Physicians with continuing medical education and research programs, expedited patient access and a variety of consulting services in areas such as physician recruitment. The two groups will provide mutually sponsored con-

tinuing medical education programs.

Joint venture expands marrow transplant program

The Indiana University Medical Center (IUMC) and Community Hospitals Indianapolis (CHI) have teamed up to expand the availability of bone marrow transplants.

This cooperative effort between the IUMC and the Regional Cancer Center at CHI will allow the expansion of the bone marrow transplant program at IUMC by developing an adult autologous bone marrow transplant program in the Regional Cancer Center inpatient area of Community Hospital East. The unit, which will have seven beds and three additional private rooms, is expected

to be ready for patients this month. The new unit will provide transplants to nearly twice as many patients as can be served currently at IUMC.

Computerized catalog available at I.U. library

The Indiana University School of Medicine Library has a new of way finding materials stored in the library. The computerized catalog, called Information Online (IO), is the online catalog for all the I.U. libraries, including the regional campuses, IUPUI and the Bloomington campus.

The catalog is accessible via telephone lines as well as in the library. There is no need for a password to use the computerized catalog, nor are there are restrictions on who can use it. The card catalog is still available, but cards have not been added or removed since early 1990.

More than 2 million records are in IO. This includes the entire collection of the medical library and some regional campuses but only about one-third of the Bloomington holdings. Medical library materials that have records in the online catalog include books, titles of journals, association publications and the uniquely titled volumes in a series. Articles in journals are not in IO but can be accessed through the periodical indexes such as *Index Medicus* or *Hospital Literature Index*.

For more information on how to use IO, call Peggy Richwine, collection database manager, (317) 274-2292. □



George Lukemeyer, M.D., (left) chairman of the Indiana University Medical School Admissions Committee, and James Carter, M.D., (second from left) associate dean for Student and Curricular Affairs, accept a \$5,000 check from Dave Duncan, (second from right) president and CEO of the Physicians Insurance Company of Indiana, and Mark Sander, (right) PICI vice president. The check is the first of a \$25,000 five-year scholarship established by PICI in honor of Martin J. O'Neill, M.D., who died July 14, 1991. The scholarship will be awarded to a student on the basis of academic excellence and financial need.

■ classifieds

PURDUE UNIVERSITY STUDENT

HEALTH CENTER is seeking a BC/BE physician to provide primary care in an active university health setting serving a student population of 36,000. Health care and prevention services are offered through outpatient and women's clinics, urgent care facilities, mental health service, physical therapy department and a progressive health promotion/patient education program. This full-time appointment offers excellent fringe benefits, including a generous vacation/holiday package, CME allowance, malpractice coverage, an outstanding retirement program, medical insurance and a light call schedule. Applicants should have a strong interest and/or experience working with college students. Please call or send CV to James S. Westman, Ph.D., Director, Purdue University Health Center, West Lafayette, IN 47907, phone (317) 494-1720. EO/AEE

GENERAL INTERNIST - BC/BE. To join a seven-man internal medicine/subspecialty group in southwestern Indiana. Salary followed by partnership offer. Reply to Managing Partner, 515 Read St., Evansville, IN 47710.

PRACTICE FOR SALE: Large family practice available in east central Indiana urban area. Excellent full-service hospital facility located in the area. Fine environment for living and raising family. Gross income of the practice averaged \$450,000 in last three years. Will remain to introduce and assist in the transition. For further details, write to P.O. Box 0983, Indianapolis, IN 46206-0983.

OHIO - WISCONSIN - MISSOURI: Attractive opportunities in metropolitan and scenic recreational areas. Locations near pristine lakes, white water rivers and national forests. Others in college communities offering professional and Big 10 college sports, fine arts and a broad spectrum of nationally renowned CME programs.

Positions available: allergy, dermatology, neurosurgery, occupational medicine, oncology, orthopaedics, psychiatry, rheumatology and urology. To discuss your practice preferences and these opportunities, please call our toll-free number, 1-800-243-4353 or send your CV to STRELCHER & ASSOCIATES, INC., 10624 N. Port Washington Road, Mequon, WI 53092.

INTERNAL MEDICINE, FAMILY PRACTICE, URGENT CARE, OB/GYN AND ACADEMICS: Positions in large metropolitan cities, urban and rural communities with a concentration in the Great Lakes area and Plains states. Whether you prefer a cosmopolitan lifestyle, a city surrounded by nature and the beauty of the four seasons, the peaceful rolling farm country or perhaps life in historic villages - there is something for everyone. To discuss your practice preferences and these opportunities, please call our toll-free number, 1-800-243-4353 or send your CV to STRELCHER & ASSOCIATES, INC., 10624 N. Port Washington Road, Mequon, WI 53092.

FAMILY PRACTICE opportunities available in Fort Wayne, Ind. Practice setting extremely flexible. Solo or group. Salary guarantee, relocation and other expenses paid. An opportunity to practice medicine and leave administrative and billing headaches to someone else. For complete details, contact our physician recruiting officer at (219) 489-2772, ext. 415.

INDIANA - A successful family medicine practice seeks a BE/BC family physician in a picturesque community 45 minutes southeast of Indianapolis. The affiliated 325-bed hospital is offering attractive, competitive financial package options. OB optional. Exceptional opportunity for a balanced professional and personal lifestyle. For further information, send CV to Andrew Johns, Physician Services of America, Suite 250, 2000 Warrington Way, Louisville, KY

40222, or call 1-800-626-1857, ext. 237.

PRIMARY CARE PHYSICIAN -

Wanted for ambulatory care center. Paid malpractice. Flexible hours. \$80,000-\$120,000 plus incentive bonus depending on hours, training and experience. Indianapolis location. Phone (317) 861-5637.

URGENT CARE - FT or PT opportunities available in busy, well-established Cedar Rapids urgent care center. Occupational medicine, including pre-employment evaluations and work-related injury treatment, is also part of the practice. X-ray, laboratory and physical therapy services available within clinic. Cedar Rapids, population 110,000, is located in eastern Iowa and is 30 minutes from the University of Iowa. Excellent compensation and scheduled hours. Mail CV or call Bob Waste, Mercy Care Management, P.O. Box 786, Cedar Rapids, IA, 52406, (319) 398-6460.

EMERGENCY CARE PHYSICIANS -

Expanding emergency services medical group seeking career-minded physicians for multiple Indiana locations. Twenty-year history without a lost contract. Hourly compensation based on training, experience and qualifications. Excellent benefits including life/health/disability and malpractice insurance plus CME allowance/ACEP and ISMA dues and pension. Will consider all physicians with emergency medicine experience and interests. Contact Jim Gardner, M.D., Corporate Development, or Steve Augustine, Physician Relations, Emergency Care Physicians, 640 S. Walker St., Suite A, Bloomington, IN 47403, (812) 333-2731.

EMERGENCY PHYSICIAN WANTED -

For Huntington Memorial Hospital in Huntington, Ind. Compensation based on training, experience and qualifications. Vacation, malpractice insurance and CME are included. Contact Stephen R.

Myron, M.D., Preferred Medical Management, P.O. Box 1897, Marion, IN 46952, (317) 668-1500.

FOR SALE: The best method of following weight-loss patients is by measuring accurately body fat composition. An electrolipograph (ELG) machine is the most accurate way of measuring body fat, next to messy water tanks. We have one for sale. It is a Bio-Analogic model including a portable computer with medical risk evaluation programs and two 24-hour blood pressure monitoring systems. A 1989 Burdick portable ECG machine with interpretation capabilities is also available. Call (404) 259-4986 or (404) 275-7090 for more information.

EMERGENCY MEDICINE - Our high-quality, low-key emergency medicine group is looking for a BC/BE or well-experienced emergency physician to join our practice at a 29,000-volume E.D. We are a fee-for-service group with good income and benefits. Full salary attained in only one year. Lafayette is a safe and pleasant college town, allowing for a high quality of living. Contact Lance Seagren or John Woods at (317) 447-4517, 1308 Lockwood Dr., Lafayette, IN 47905.

DOOR COUNTY, WISCONSIN - BC/BE internist. Modern, 89-bed community hospital with new outpatient services addition. Competitive guaranteed salary. Incentive package. Malpractice insurance. Attractive benefits. Exceptional four seasons recreation along Lake Michigan shores. Proximity to Milwaukee/Chicago. Top-rated schools. Quality community life. Send CV to Priscilla Khoury, Physician Recruitment Coordinator, 330 S. 16th Place, Sturgeon Bay, WI 54235.

INDIANA/PEDIATRICS - Premier opportunity for a BE/BC pediatrician to initiate a practice in association with three well-established pediatricians. A competitive finan-

cial package is being offered for this practice that has a balanced patient mix and good call coverage. The 235-bed community hospital has a level II nursery with 28 pediatric beds. This economically thriving city of 33,000 is located 65 miles northeast of Indianapolis, 50 miles southwest of Fort Wayne and 35 miles northwest of Muncie. Send CV to Andrew Johns, Physician Services of America, Suite 250, 2000 Warrington Way, Louisville, KY 40222 or call 1-800-626-1857, ext. 237.

DOOR COUNTY, WISCONSIN - Emergency medicine. BC/BE family practice, internal medicine, pediatrics or emergency medicine. General emergency medicine experience required. ACLS/ATLS required, PALS preferred. Full-time position with 8-10 24-hour shifts monthly with flexibility. Competitive salary and benefits package. Modern 89-bed hospital with a new emergency department and outpatient services addition. Approximately 10,000 visits per year. Exceptional four seasons recreation along Lake Michigan shores. Proximity to Milwaukee/Chicago. Top-rated schools. Quality community life. Send CV to Priscilla Khoury, Physician Recruitment Coordinator, 330 S. 16th Place, Sturgeon Bay, WI 54235.

IMMEDIATE CARE PHYSICIANS - Expanding immediate care Indianapolis-based group seeks career-minded primary physicians for multiple clinical locations. Ten-year profitable history second to none in the metropolitan Indianapolis area. Physician-owned and operated. Corporation. Compensation based on training, experience and qualifications. Excellent benefits including life/health/disability and malpractice insurance plus CME allowance/state and local dues and pension. Will consider all primary medical disciplines with interest in outpatient medicine. All candidates selected for F/T opportunities only. Contact Steven K.

Augustine, Director, Physician Relations, Immediate Care Centers, c/o 640 S. Walker St., Suite A, Bloomington, IN 47403, (812) 333-2731.

HEMATOLOGY-ONCOLOGY: Private practice in southwest Indiana looking for associate leading to partnership. Extensive referral listings and excellent health care facilities. Respond to Tri-State Hematology Oncology, P.O. Box 5069, Evansville, IN 47716-5069.

WANTED: Physician to help family physician who wants to spend four to five months in Florida and work two to three days while in Lebanon, Ind. Free rent offered in my office next to Witham Hospital. Contact Jack L. Lenox, M.D., 1202 N. Lebanon St., Lebanon, IN 46052, (317) 482-5970.

FAMILY PRACTITIONERS/INTERNISTS - MetroHealth, an affiliate of Methodist Hospital of Indiana, Inc., is seeking board-certified/eligible family practitioners and internists. Share the advantages of joining an established prepaid multi-specialty physician group offering an ideal blend of practice and lifestyle, paid professional liability and competitive compensation and fringe benefit packages. Our practice is located in Indianapolis, a thriving Midwest community offering a number of cultural, educational and recreational activities. For confidential consideration, submit curriculum vitae to MetroHealth Physician Recruitment, P.O. Box 1367, Indianapolis, IN 46206.

IPRO-LIFE OBSTETRICS AND GYNECOLOGY group seeks a third associate for a rapidly expanding practice. Retirement of three OB/GYNs within 18 months has created a dramatic need for expansion in this specialty. Take advantage of the recreational possibilities of nearby Michigan while enjoying the professional advantages of practice in Indiana. Call or write Jeffrey L. Cain, M.D., West

■ classifieds

Side Obstetrics & Gynecology, P.C., Elkhart, IN 46514, (219) 293-6999.

MULTIPLE AND VARIED physician practice opportunities currently exist both within and outside Indiana. Call Patti Quiring at work, (317) 841-7575, or at home, (317) 823-4746. Patti is a physician recruiter for Quiring Associates, an executive search firm headquartered in Indianapolis.

GENERAL INTERNIST - BC/BE. To join a busy five-man practice with

special interest in hospital intensive care, plus consultative and primary care practice in the Indianapolis area. Will offer partnership. Reply to Box 19616, Indianapolis, IN 46219.

EMERGENCY MEDICINE - Terre Haute, Ind. Local multi-hospital group seeking full-time career-oriented emergency physician for position in small- and medium-volume community hospitals. Flexible scheduling, very competitive compensation package, partnerships available. Send CV or con-

tact William R. Grannen, Priority Health Care, P.C., 7179 Lamplite Ct., Cincinnati, OH 45244, (513) 231-0922.

CENTRAL INDIANA - Physician-owned emergency group accepting applications for full-time, career-oriented emergency physicians. Flexible work schedules and excellent benefit package. Part-time and directorship positions also available. Send CV or contact Midwest Medical Management, Inc., 3645 S. East St., Indianapolis, IN 46227-1240, (317) 783-7474. □

Classified advertising rates

Classified advertisements are published as a service to members of the Indiana State Medical Association. Only ads considered to be of advantage to members will be accepted. Advertisements of a truly commercial nature (ie: firms selling brand products, services, etc.) will be considered for display advertising. All orders must be in writing and will automatically be set in regular classified type. Box numbers are not available.

Charges:

- * ISMA members25¢/word (\$15 minimum)
- * Non-members75¢/word (\$30 minimum)

Deadline: Six weeks preceding month of publication.

Payment procedure: Payment in advance is not required. Invoices and tearsheets are mailed to advertisers upon publication. INDIANA MEDICINE is issued on the 10th of the month six times a year, in January, March, May, July, September and November.

Address: INDIANA MEDICINE, 322 Canal Walk, Indianapolis, IN 46202-3252.

Advertisements for employment containing specifications as to race, creed, color, age, religion, sex, ethnic origin or national origin may be unlawful and professionally improper. Accordingly, discriminatory wording is not acceptable in INDIANA MEDICINE. In such a case, INDIANA MEDICINE will modify the wording and notify the advertiser of the change.

OFFICERS

President — C. Dyke Egnatz, Schererville
 Pres.-elect — William H. Beeson, Indianapolis
 Immediate Past Pres — Michael O. Mellinger, LaGrange
 Executive Director — Richard R. King, Indianapolis
 Treasurer — John A. Bizal, Evansville
 Asst. Treasurer — Timothy Brown, Crawfordsville
 Speaker — William C. Van Ness II, Summitville
 Vice Speaker — William E. Cooper, Columbus

EXECUTIVE COMMITTEE

*C. Dyke Egnatz, Schererville
 William H. Beeson, Indianapolis
 Michael O. Mellinger, LaGrange
 Peter Winters, Indianapolis
 John A. Bizal, Evansville
 Timothy Brown, Crawfordsville
 Alfred Cox, South Bend
 Jerome Melchior, Vincennes
 William C. Van Ness II, Summitville
 William E. Cooper, Columbus

TRUSTEES (Terms end in October)

District

1 — Bruce Romick, Evansville (1992)
 2 — Jerome E. Melchior, Vincennes (1993)
 3 — Gordon L. Gutmann, Jeffersonville (1994)
 4 — Arthur C. Jay, Lawrenceburg (1992)
 5 — Ered E. Haggerty, Greencastle (1993)
 6 — Ray Haas, Greenfield (1994)
 7 — Donna J. Meade, Indianapolis (1992)
 7 — John M. Records, Franklin (1993)
 *7 — Peter L. Winters, Indianapolis (1992)
 8 — John V. Osborne, Muncie (1993)
 9 — Stephen Tharp, Frankfort (1994)
 10 — Nicholas L. Polite, Hammond (1992)
 11 — Jack W. Higgins, Kokomo (1993)
 12 — John R. Thomas, Fort Wayne (1994)
 13 — Alfred C. Cox, South Bend (1992)
 RMS — Rick Robertson, Indianapolis (1992)
 MSS — Andre Stoval, Indianapolis (1992)
 *Chairman

ALTERNATE TRUSTEES (Terms end in October)

District

1 — Barney R. Maynard, Evansville (1994)
 2 — James P. Beck, Washington (1992)
 3 — John H. Seward, Bedford (1992)
 4 — Robert L. Eorste, Columbus (1994)

5 — Roland M. Kohr, Terre Haute (1994)
 6 — Howard C. Deitsch, Richmond (1992)
 7 — Ronald G. Blankenbaker, Indianapolis (1994)
 7 — Bernard J. Emkes, Indianapolis (1992)
 7 — Charles O. McCormick III, Greenwood (1993)
 8 — Susan K. Pyle, Union City (1994)
 9 — Robert F. Darnaby, Rensselaer (1992)
 10 — Frank M. Sturdevant, Valparaiso (1994)
 11 — Laurence K. Musselman, Marion (1992)
 12 — Charles M. Frankhouser, Fort Wayne (1992)
 13 — Richard J. Houck, Michigan City (1994)
 RMS — Carla Brumbaugh, Indianapolis (1992)
 MSS — Ruchir Sehra, Indianapolis (1992)

AMA DELEGATES (Terms end Dec. 31)

Marvin E. Priddy, Fort Wayne (1993)
 John D. MacDougall, Beech Grove (1993)
 Herbert Khalouf, Marion (1993)
 John A. Knotz, Lafayette (1992)
 Alvin J. Haley, Carmel (1992)
 George T. Lukemeyer, Indianapolis (1992)

AMA ALTERNATE DELEGATES (Terms end Dec. 31)

Michael O. Mellinger, LaGrange (1993)
 George Rawls, Indianapolis (1993)
 Richard L. Reedy, Yorktown (1993)
 Shirley Thompson Khalouf, Marion (1992)
 Max N. Hoffman, Covington (1992)
 Edward L. Langston, Indianapolis (1992)

DISTRICT OFFICERS AND MEETINGS

1 — Pres: Richard A. Tibbals, Evansville
 Secy: Rex H. Ragsdale, Evansville
 Annual Meeting: May 21, 1992
 2 — Pres: Paul Daluga, Linton
 Secy: Frederick R. Ridge, Jr., Linton
 Annual Meeting: May 14, 1992
 3 — Pres: Stephen R. Havens, Jeffersonville
 Secy: Olegario J. Ignacio, Jeffersonville
 Annual Meeting: May 20, 1992
 4 — Pres: Robert L. Eorste, Jr., Columbus
 Secy: Jeffery C. Hagedorn, Columbus
 Annual Meeting: May 6, 1992
 5 — Pres: James R. Rudolph, Greencastle
 Secy: Peggy Sankey-Swain, Rockville
 Annual Meeting: May 28, 1992
 6 — Pres: Robert W. Maitlen, Connersville
 Secy: William H. Toedebusch, Richmond
 Annual Meeting: May 13, 1992

7 — Pres: Bernard J. Emkes, Indianapolis
 Secy: H. Marshall Trusler, Greenfield
 Annual Meeting: May 27, 1992
 8 — Pres: Robert J. Helm, Elwood
 Secy: Gary Brazel, Anderson
 Annual Meeting: June 3, 1992
 9 — Pres: Robert F. Darnaby, Rensselaer
 Secy: Stephen D. Tharp, Frankfort
 Annual Meeting: June 11, 1992
 10 — Pres: Hilemon P. Lopez, Dyer
 Secy: Barron M. Palmer, Hammond
 Annual Meeting: June 17, 1992
 11 — Pres: Regino Urgena, Marion
 Secy: Frederick C. Poehler, La Fontaine
 Annual Meeting: Sept. 16, 1992
 12 — Pres: William Aeschliman, Fort Wayne
 Secy: Joseph Manthey, Bluffton
 Annual Meeting: Sept. 17, 1992
 13 — Pres: David Haines, Warsaw
 Secy: John W. Schurz, South Bend
 Annual Meeting: Sept. 9, 1992

COMMISSION CHAIRMEN

Constitution and Bylaws

Helen E. Czenkusch, Indianapolis

Legislation

Eugene G. Roach, Anderson

Physician Assistance

Robert Nelson, South Bend

Medical Services

Dallas E. Coate, Lebanon

Medical Education

James E. Carter, Indianapolis

Sports Medicine

Ronald G. Blankenbaker, Indianapolis

COMMITTEE CHAIRMEN

Medical Malpractice (Ad Hoc)

George T. Lukemeyer, Indianapolis

Grievance

Richard B. Schnute, Indianapolis

Indiana Medical Foundation

Frank B. Ramsey, Indianapolis

CHAIRMEN OF ISMA SPECIALTY SECTIONS

ALLERGY

Paul D. Isenberg, Indianapolis

ANESTHESIOLOGY

Stephen F. Dierdorf, Indianapolis

CUTANEOUS MEDICINE

Peter L. Winters, Indianapolis

DIRECTORS MEDICAL EDUCATION

Glenn Bingle, Indianapolis

EMERGENCY MEDICINE

Thomas C. Madden, Greenwood

FAMILY PRACTICE

Dallas E. Coate, Lebanon

INTERNAL MEDICINE

Neil Irick, Indianapolis

MEDICAL DIRECTORS AND STAFF PHYSICIANS

OF NURSING FACILITIES

Larry G. Cole, Yorktown

NEUROLOGICAL SURGERY

Marvin R. Bernard, Merrillville

NEUROLOGY

Charles A. Bonsett, Indianapolis

NUCLEAR MEDICINE

Mike Mullinix, Indianapolis

OBSTETRICS & GYNECOLOGY

Philip N. Eskew Jr., Carmel

OPHTHALMOLOGY

D. Dean Cofield, Bloomington

ORTHOPAEDIC SURGERY

James G. Buchholz, Fort Wayne

OTOLARYNGOLOGY, HEAD & NECK SURGERY

William E. Cooper, Columbus

PATHOLOGY & FORENSIC MEDICINE

Joyce Byllesby, Washington

PEDIATRICS

Charlene Graves, Indianapolis

PHYSICAL MEDICINE AND REHABILITATION

Robert Gregori, Indianapolis

PREVENTIVE MEDICINE AND PUBLIC HEALTH

Gary A. Babcoke, Chesterton

PSYCHIATRY

Patricia Sharpley, Indianapolis

RADIOLOGY

Gonzalo T. Chua, Indianapolis

SURGERY

Robert Lempke, Indianapolis

UROLOGY

Rodney A. Mannion, LaPorte

ISMA KEY STAFF

Richard R. King, Executive Director

Adele Lash, Director of Operations/Communications

Mike Abrams, Director of Marketing/Legislation

John Wilson, Director of Administration

Ronald Dyer, General Counsel

Susan Grant, Executive Assistant

Richard Ryan, Field Services (Northern)

Bob Sullivan, Field Services (Central)

Janna Kosinski, Field Services (Southern)

Barbara Walker, Reimbursement Coordinator

Marvona Welsh, Reimbursement Coordinator

Tom Martens, Members Health Insurance

Tina Sims, INDIANA MEDICINE

Mark Your Calendars!

WHO: ISMA
Members

WHAT: Annual
Convention

WHEN: Oct. 16-18,
1992

WHERE: Westin Hotel
in downtown
Indianapolis

Advertising index

AdminaStar Electronic Services	187
Affiliated Physicians Services	Cover
American Medical Association	208, 256
American Medical Services	211, 226
Arnett Clinic	215
Auto Buyers Network	259
Butterworth Health System	195
Central Pharmaceuticals	205
Lilly, Eli & Co.	216, 217
Little Red Door Cancer Agency	261
Medical Accounts Group	204, 205
Medical Protective	235
Palisades Pharmaceuticals	233
Parke-Davis Laboratories	193, 194
Physicians' Directory	236
Physicians Insurance Co. of Indiana	Cover
Postgraduate Medicine	186
Professional Billing Service	259
Records Management Services	217
Roche Laboratories	189, 209, 210
G.D. Searle and Company	Cover
Spectrum Emergency Care	211
Speedway Mazda	233
University Place	191
U.S. Air Force	227

In accepting advertising for publication, INDIANA MEDICINE has exercised reasonable precaution to ensure that only reputable, factual advertisements are included. However, we do not have facilities to make comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services, medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertisers only. Neither sanction nor endorsement of such is warranted, stated or implied by the association.

Are you moving?

If so, please send change of address to the Indiana State Medical Association, Membership Department, 322 Canal Walk, Indianapolis, IN 46202-3252, at least six weeks before you move.

Name: _____

Address: _____

City: _____

State: _____ Zip: _____ County: _____

Office phone: _____ Home phone: _____

IMPORTANT - Attach mailing label from your last copy of INDIANA MEDICINE here:

ISMA Health/Dental Insurance

Benefits available to members of the Indiana State Medical Association and their employees through expanded ISMA group sponsored health insurance.

MEDICAL PLAN A

- 365 Days of Inpatient Hospital Care
- 100% payment semi-private or hospital ward room
- 365 Days In-Hospital Medical Care
- 100% reasonable and customary allowances for surgery, maternity, general anesthesia, medical visits, radiation therapy, and other eligible inpatient hospital charges
- \$2,000,000 Major Medical Benefits (\$100 deductible)

MEDICAL PLAN B

- Comprehensive Major Medical protection
- \$250 calendar year deductible, \$500 per family
- Stop-Loss Limit \$5,000 per person, \$10,000 per family
- PCS Card
- Includes cost-containment features
- \$2,000,000 Maximum Benefits

MEDICAL PLAN C

- Comprehensive Major Medical protection
- \$500 calendar year deductible, \$1,000 per family
- Stop-Loss Limit \$5,000 per person, \$10,000 per family
- \$2,000,000 Maximum Benefits

MEDICAL PLAN D

- Economical Comprehensive Major Medical protection
- \$1,000 calendar year deductible, \$2,000 per family
- Stop-Loss Limit \$5,000 per person, \$10,000 per family
- \$2,000,000 Maximum Benefits

MEDICAL PLAN E

- Low cost Comprehensive Major Medical protection
- \$2,000 calendar year deductible, \$6,000 per family
- Stop-Loss Limit \$10,000 per person, \$30,000 per family
- \$2,000,000 Maximum Benefits

BENEFITS FOR ORGAN OR TISSUE TRANSPLANTS

- Included with all medical plans
- Subject to normal plan deductibles and co-insurance
- Covered Transplant Procedures: This benefit covers any of the following human to human organ or tissue transplants: bone marrow; heart; heart/lung; liver; kidney; cornea
- Artery or vein transplants
- Joint replacements
- Heart valve replacements
- Implantable prosthetic lenses in connection with cataracts
- Prosthetic by-pass or replacement vessels
- Maximum Transplant Benefit: \$1,000,000 lifetime maximum per person for all transplant services

DENTAL PLAN

- Reasonable and customary allowances for necessary care and treatment for dental health - \$50 calendar year deductible, \$100 per family
- \$1,500 maximum dental benefit per person in a calendar year paid at 80%, additional major dental paid at 50%
- \$1,000 Orthodontia Benefits paid at 50% of reasonable and customary charges

MEDICAL REIMBURSEMENT PLAN

- Tax deductible to the professional corporation

Your benefit programs have been designed to provide the highest quality coverage and service at the lowest possible cost. A special claim paying unit has been established to handle only the ISMA program. Should you have questions or problems, you may speak directly to your claim processor. We look forward to serving you and encourage your review of the program and services being provided.

For more information regarding these coverages contact:

Tom Martens
Director, Health Insurance Administration
Indiana State Medical Association
322 Canal Walk
Indianapolis, Indiana 46202-3252
(317) 261-2060
800-969-7545 Indiana
FAX (317) 261-2076

Earl W. Williams
Professional Account Representative
11595 N. Meridian St., Suite 802
Carmel, Indiana 46032
(317) 573-6520
800-421-3020
FAX (317) 573-6524

AFFILIATED PHYSICIANS SERVICES, INC.

ISMA Agency

For the many faces of mild hypertension



THE MOST WIDELY USED CALCIUM ANTAGONIST AS MONOTHERAPY FOR MILD HYPERTENSION^{1*}

- Effective 24-hour control²
- Single-agent efficacy
- Well tolerated³
- No adverse effects on total cholesterol, plasma glucose levels, renal function, or serum electrolytes⁴



For the many faces of mild hypertension

*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

† Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡ Verapamil should be administered cautiously to patients with impaired renal function.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully

monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecostasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6277V

Address medical inquiries to:
G.D. Searle & Co.
Medical & Scientific
Information Department
4901 Searle Parkway
Skokie, IL 60077

SEARLE

G.D. Searle & Co.
Box 5170, Chicago, IL 60680

INDIANA MEDICINE

The Journal of the Indiana State Medical Association

July/August 1992

Vol. 85, No. 4

Is there a

GAP

in Primary Care?



Choosing PICI is an open and shut case

With PICI's track record for success in defending claims, it would be easy for us to rest on our laurels. But after all of our successes and words of gratitude from our physician policyholders, we still get defensive.

As a physician-owned company, dedicated to our insureds and their practices, we always defend against claims that have no merit. We do not settle suits to save money. In fact, we can not settle without your consent. Never have, never will.

When an insured's reputation is on the line, so is PICI's.

We're proud to say we're defensive. It's a way of doing business that has yielded positive results, to the relief and satisfaction of our policyholders.



**PHYSICIANS INSURANCE
COMPANY OF INDIANA**

8425 Woodfield Crossing Blvd., Suite 300
Indianapolis, IN 46240
317/469-4100 800/284-7424

Indiana
State
Medical
Association 

"Together, We Make The Difference"

INDIANA MEDICINE

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON, MA

OCT 21 1992

The Journal of the Indiana State Medical Association

July/August 1992

Vol. 85, No. 4

features

IU dean examines primary care issue278

INDIANA MEDICINE interviews Walter Daly, M.D., dean of the Indiana University School of Medicine and director of the IU Medical Center, on his perspectives on the primary care issue.

Recruiting doctors: Big job for small towns284

Administrators of rural Indiana hospitals must be creative when trying to recruit primary care physicians.

Rural physicians have chance to make a difference288

Despite long hours and reimbursement inequities, rural physicians generally enjoy practicing in small-town Indiana.

Digest of health and medical laws293

New faces in statehouse may change ISMA strategy302

The ISMA faces the challenge of educating new legislators about issues affecting health care.

Rabies in Indiana: It's still a threat308

Rabies still remains a threat in Indiana despite great strides in protecting the public from the disease.

Working vacations in the Third World for physicians and dentists312

Volunteer working vacations provide physicians with an opportunity to immerse themselves in a different culture while providing care to patients who might otherwise have none.

Snakeroot Extract319

scientific contribution

PCP presenting as cavitary pneumonia: A case report314



Cover stories on pages 278, 284 and 288. Cover design by Diane Alfonso, Indianapolis.

departments

stethoscope	274
isma leadership	276
drug names	313
auxiliary report	318
from the museum	346
cme calendar	348
news briefs	349
obituaries	350
people	352
classifieds	355

Mazda

A REVOLUTION IN LUXURY CARS. THE NEW MAZDA 929.



Mazda 929 Luxury Sedan

Revolutionary in concept,
strikingly original in execution,
the **Mazda 929** is
one luxury car that makes a
truly personal statement.

- 195-hp 24-valve V6 tuned for American driving conditions
- Roomy interior, centered around the driver
- Dual air bags - standard equipment
- Anti-lock Brake System - standard equipment
- New-generation multi-link suspension for ideal combination of ride and handling
- Special lease program

**Find out for yourself today at
Indiana's #1 Mazda Dealer
(317)263-0002**

**Speedway Mazda
1935 W. 16th St.
Indpls, IN 46202**

INDIANA MEDICINE

Devoted to the interests of the medical profession and public health in Indiana since 1908.

MANAGING EDITOR

Tina Sims

EDITORIAL ASSISTANT

Toni Settle

BUSINESS MANAGER

Richard R. King

CIRCULATION

Rosanna Iler

EDITORIAL BOARD CHAIRMAN

George T. Lukemeyer, M.D.

EDITORIAL BOARD

Thomas J. Conway, M.D.

Robert C. Ziss, M.D.

(Terms expire Dec. 31, 1992)

James R. Buechler, M.D.

James W. Edmondson, M.D.

Robert L. Forste Jr., M.D.

George C. Manning, M.D.

Bruce F. Waller, M.D.

(Terms expire Dec. 31, 1993)

Franklin Roesner

Paul Forman

(Medical students)

CONSULTING EDITORS

Steven C. Beering, M.D.

Charles A. Bonsett, M.D.

Walter J. Daly, M.D.

Alvin J. Haley, M.D.

Rodney A. Mannion, M.D.

Alan T. Marty, M.D.

EDITOR EMERITUS

Frank B. Ramsey, M.D.

INDIANA MEDICINE (ISSN 0746-8288) is published six times a year (in January, March, May, July, September and November) by the Indiana State Medical Association. Second-class postage paid at Indianapolis, Ind., and additional mailing offices.

Address correspondence relating to editorial material, advertising or subscriptions to: INDIANA MEDICINE, 322 Canal Walk, Indianapolis, IN 46202-3252. Phone (317) 261-2060 or 1-800-257-ISMA.

Annual subscription rates for nonmembers: \$15 domestic, \$17 Canada, \$18 foreign. Medical library rates: \$14 domestic, \$15 Canada, \$16 foreign. Full-time Indiana medical students: \$7. Single copies not available. Subscriptions are renewable annually.

POSTMASTER: Send address changes to INDIANA MEDICINE, Indiana State Medical Association, c/o Membership Department, 322 Canal Walk, Indianapolis, IN 46202-3252.

Views expressed do not reflect the opinions of the editors. No copyright is claimed, unless specifically indicated. Copyright rests solely with authors, who are responsible for statements in their articles. Scientific and editorial contributions are accepted for exclusive publication, subject to editorial requirements. Instructions for authors available on request.

All issues since 1967 are available on microfilm from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, MI 48106. Indexed in *Index Medicus* and *Hospital Literature Index*.

Advertising rates and data available upon request. INDIANA MEDICINE reserves the right to accept or reject advertising.

RBRVS

MFS

EM

CF

AHPB

CHAOS

CPT

GPCI

RVU

HCEA

GAF

serenity.

Our accounts receivable management program includes comprehensive service bureau billing, expert profile review and coding assistance, physician reports, and regulatory updates.

Isn't that just what you'd expect from the medical billing expert? Call us today...
you can't afford not to.


Medical Accounts Group
INCORPORATED

3901 North Meridian Street • Suite 200
Indianapolis, IN 46208
IN (317) 923-3046 • USA (800) 527-6244

ISMA continues media visits to discuss malpractice law

The ISMA is continuing its visits with media representatives throughout the state to discuss the Indiana Compensation Act for Patients (INCAP), the state's medical malpractice law. Timothy Brown, M.D., Crawfordsville, discussed how INCAP benefits both physicians and patients during a June 10 visit to the *Pharos-Tribune* and WSAL radio in Logansport, radio stations WKUZ and WAYT in Wabash, *The Tipton Tribune* and *The Frankfort Times*. During the June 16 visit, Dr. Brown and William Beeson, M.D., Indianapolis, discussed INCAP at Bloomington radio stations WGCL, WTTS and WFIU; *The Bloomington Herald-Times*; *The Bedford Times-Mail*; and *The Seymour Daily Tribune*. Jerome E. Melchior, M.D., Vincennes, represented the ISMA during the June 17 visit to Hammond radio station WJOB, *The Hammond Times* and *The Gary Post-Tribune*.

Legislative study committee hears testimony on INCAP

Representatives from the ISMA, Physicians Insurance Company of Indiana and The Medical Protective Company testified June 24 at a meeting of the Interim Study Committee on Insurance on the procedures of the Indiana Compensation Act for Patients (INCAP). The representatives identified the public policy benefits of INCAP and explained the crisis situation in 1975 that necessitated the act.

The interim study committee, appointed by the Legislative Council, consists of six members of the Indiana House of Representatives and six Senate members. Senate members are: Democrats – Joseph O'Day, Louis Mahern and Bill Alexa; Republicans – Joe Harrison, Richard Worman and Tom Weatherwax, co-chairman. House members are: Democrats – Craig Fry, chairman; Ed Gobel and Earl Howard; and Republicans – Brian Bosma, Phyllis Pond and Jerry Bales.

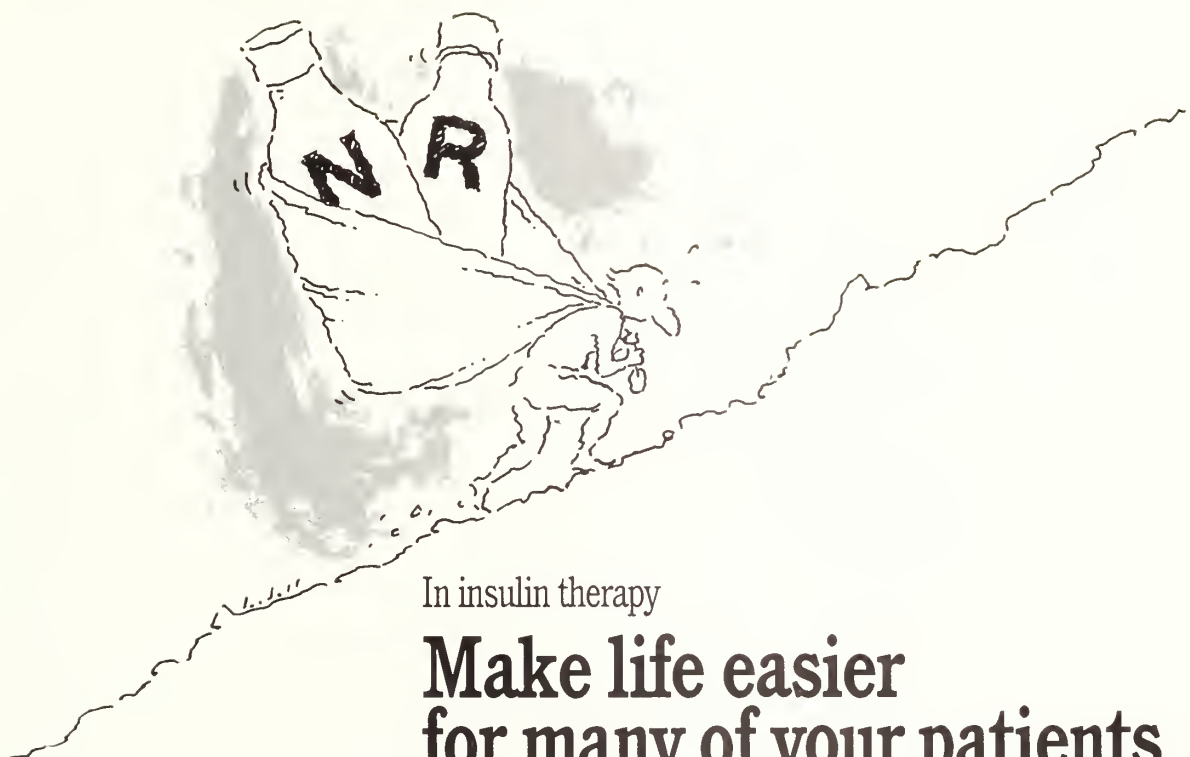
In other committee hearings, representatives from the Medical Licensing Board, Department of Insurance and the Indiana Trial Lawyers Association will testify.

Syndicated columnist to speak at annual ISMA convention

The ISMA will hold its 143rd annual convention and exposition Oct. 16 to 18 at the Westin Hotel in Indianapolis. The event will include the House of Delegates, specialty society meetings, a one-day exhibition, a luncheon and reception in the exhibit hall, the President's Night dinner and the IMPAC luncheon. Cal Thomas, a nationally syndicated newspaper columnist and 29-year veteran of broadcast and print media, will speak at the IMPAC luncheon Oct. 17. Five Easy Pieces, an Indianapolis band whose repertoire ranges from swing to current dance hits, will perform for President's Night.

The deadline for submitting 1992 resolutions for the ISMA House of Delegates is Aug. 17. Resolutions should be sent to the ISMA, attn: Mary Alice Cary, 322 Canal Walk, Indianapolis, IN 46202-3252.

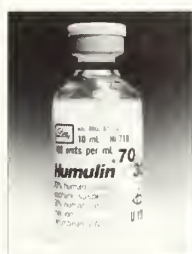
A convention brochure will be mailed to all physicians in August. ■



In insulin therapy

Make life easier for many of your patients

Humulin 70/30. Convenient and simple to administer.



No more mixing. No more mixing errors. All of which makes living with diabetes a little easier for patients. And compliance a lot easier to achieve.

Humulin[®] 70/30

70% human insulin isophane suspension
30% human insulin injection
(recombinant DNA origin)



Global Excellence in Diabetes Care

Eli Lilly and Company
Indianapolis, Indiana
46285

The patient-friendly premix

WARNING: Any change of insulin should be made cautiously and only under medical supervision.

HI-7905-B-249327 ©1992, ELI LILLY AND COMPANY

isma leadership

OFFICERS

President — C. Dyke Egnatz, Schererville
 Pres.-elect — William H. Beeson, Indianapolis
 Immediate Past Pres. — Michael O. Mellinger, LaGrange
 Executive Director — Richard R. King, Indianapolis
 Treasurer — John A. Bizal, Evansville
 Asst. Treasurer — Timothy Brown, Crawfordsville
 Speaker — William C. Van Ness II, Summitville
 Vice Speaker — William F. Cooper, Columbus

EXECUTIVE COMMITTEE

*C. Dyke Egnatz, Schererville
 William H. Beeson, Indianapolis
 Michael O. Mellinger, LaGrange
 Peter Winters, Indianapolis
 John A. Bizal, Evansville
 Timothy Brown, Crawfordsville
 Alfred Cox, South Bend
 Jerome Melchior, Vincennes
 William C. Van Ness II, Summitville
 William F. Cooper, Columbus

TRUSTEES (Terms end in October)

District
 1 — Bruce Romick, Evansville (1992)
 2 — Jerome L. Melchior, Vincennes (1993)
 3 — Gordon L. Gutmann, Jeffersonville (1994)
 4 — Arthur C. Jay, Lawrenceburg (1992)
 5 — Fred J. Haggerty, Greencastle (1993)
 6 — Ray Haas, Greentfield (1994)
 7 — Donna J. Meade, Indianapolis (1992)
 8 — John M. Records, Franklin (1993)
 9 — Peter L. Winters, Indianapolis (1994)
 10 — John V. Osborne, Muncie (1993)
 11 — Stephen Tharp, Frankfort (1994)
 12 — Nicholas L. Polite, Hammond (1992)
 13 — Jack W. Higgins, Kokomo (1993)
 14 — John R. Thomas, Fort Wayne (1994)
 15 — Alfred C. Cox, South Bend (1992)
 RMS — Rick Robertson, Indianapolis (1992)
 MSS — Andre Stovall, Indianapolis (1992)
 *Chairman

ALTERNATE TRUSTEES (Terms end in October)

District
 1 — Barney R. Maynard, Evansville (1994)
 2 — James P. Beck, Washington (1992)
 3 — John H. Seward, Bedford (1992)
 4 — Robert L. Forster, Columbus (1994)

5 — Roland M. Kohr, Terre Haute (1994)
 6 — Howard C. Deitsch, Richmond (1992)
 7 — Ronald G. Blankenbaker, Indianapolis (1994)
 8 — Bernard J. Emkes, Indianapolis (1992)
 9 — Charles O. McCormick III, Greenwood (1993)
 10 — Susan K. Pyle, Union City (1994)
 11 — Robert F. Darnaby, Rensselaer (1992)
 12 — Frank M. Sturdevant, Valparaiso (1994)
 13 — Laurence K. Musselman, Marion (1992)
 14 — Charles M. Frankhouser, Fort Wayne (1992)
 15 — Richard J. Houck, Michigan City (1994)
 RMS — Carla Brumbaugh, Indianapolis (1992)
 MSS — Ruchir Sehra, Indianapolis (1992)

AMA DELEGATES (Terms end Dec. 31)

Marvin E. Priddy, Fort Wayne (1993)
 John D. MacDougall, Beech Grove (1993)
 Herbert Khalout, Marion (1993)
 John A. Knote, Lafayette (1992)
 Alvin J. Haley, Carmel (1992)
 George T. Lukemeyer, Indianapolis (1992)

AMA ALTERNATE DELEGATES (Terms end Dec. 31)

Michael O. Mellinger, LaGrange (1993)
 George Rawls, Indianapolis (1993)
 Richard L. Reedy, Yorktown (1993)
 Shirley Thompson Khalout, Marion (1992)
 Max N. Hoffman, Covington (1992)
 Edward L. Langston, Indianapolis (1992)

DISTRICT OFFICERS AND MEETINGS

1 — Pres. Gregory Hindahl, Jasper
 Secy. Mariellen Pentino, Evansville
 Annual Meeting, May 20, 1993
 2 — Pres. Bill Vaughn, Vincennes
 Secy. Mike Kelly, Vincennes
 Annual Meeting, May 13, 1993
 3 — Pres. John Norton, Corydon
 Secy. Rashidul Islam, New Salisbury
 Annual Meeting, May 19, 1993
 4 — Pres. Manuel Garcia, Batesville
 Secy. David Welsh, Batesville
 Annual Meeting, May 5, 1993
 5 — Pres. Paul Houston, Brazil
 Secy. Rahim Farid, Brazil
 Annual Meeting, May 27, 1993
 6 — Pres. William Loedebusch, Richmond
 Secy. Helen Steussy, New Castle
 Annual Meeting, May 12, 1993

CHAIRMEN OF ISMA SPECIALTY SECTIONS

ALLERGY — David D. Isenberg, Indianapolis
 ANTHROPOLOGY — Stephen E. Dreidort, Indianapolis
 CUTANEOUS MEDICINE — Peter L. Winters, Indianapolis
 DIRECTORS MEDICAL EDUCATION — Glenn Bingle, Indianapolis
 EMERGENCY MEDICINE — Thomas C. Madden, Greenwood
 FAMILY PRACTICE — Dallas E. Coate, Lebanon
 INTERNAL MEDICINE — Neil Erick, Indianapolis
 MEDICAL DIRECTORS AND STAFF PHYSICIANS OF NURSING FACILITIES — Larry G. Cole, Yorktown
 NEUROLOGICAL SURGERY — Marvin R. Bernard, Merrillville
 NEUROLOGY — Charles A. Bonsett, Indianapolis
 NUCLEAR MEDICINE — Mike Mullins, Indianapolis

OBSTETRICS & GYNECOLOGY — Philip N. Eskew Jr., Carmel
 OPHTHALMOLOGY — D. Dean Cofield, Bloomington
 ORTHOPAEDIC SURGERY — James G. Buchholz, Fort Wayne
 OTOLARYNGOLOGY, HEAD & NECK SURGERY — William F. Cooper, Columbus
 PATHOLOGY & FORENSIC MEDICINE — Joyce Byllesby, Washington
 PEDIATRICS — Charlene Graves, Indianapolis
 PHYSICAL MEDICINE AND REHABILITATION — Robert Gregori, Indianapolis
 PREVENTIVE MEDICINE AND PUBLIC HEALTH — Gary A. Babcock, Chesterton
 PSYCHIATRY — Patricia Sharpley, Indianapolis
 RADIOLOGY — Gonzalo T. Chua, Indianapolis
 SURGERY — Robert Lempke, Indianapolis
 UROLOGY — Rodney A. Mannion, LaPorte

7 — Pres. Ronald Stegemoller, Danville
 Secy. Craig Moorman, Franklin
 Annual Meeting, to be announced
 8 — Pres. Gordon M. Hughes, Muncie
 Secy. Gerard T. Costello, Muncie
 Annual Meeting, June 2, 1993
 9 — Pres. Robert E. Darnaby, Rensselaer
 Secy. Stephen D. Tharp, Frankfort
 Annual Meeting, June 11, 1992
 10 — Pres. Filemon P. Lopez, Dyer
 Secy. Barron M. Palmer, Hammond
 Annual Meeting, June 17, 1992
 11 — Pres. Regino Urgena, Marion
 Secy. Frederick C. Poehler, La Fontaine
 Annual Meeting, Sept. 16, 1992
 12 — Pres. William Aeschliman, Fort Wayne
 Secy. Joseph Manthey, Bluffton
 Annual Meeting, Sept. 17, 1992
 13 — Pres. David Haines, Warsaw
 Secy. John W. Schurz, South Bend
 Annual Meeting, Sept. 9, 1992

COMMISSION CHAIRMEN

Constitution and Bylaws
 Helen E. Czenkusch, Indianapolis
Legislation
 Eugene G. Roach, Anderson
Physician Assistance
 Robert Nelson, South Bend
Medical Services
 Dallas E. Coate, Lebanon
Medical Education
 James E. Carter, Indianapolis
Sports Medicine
 Ronald G. Blankenbaker, Indianapolis

COMMITTEE CHAIRMEN

Medical Malpractice (Ad Hoc)
 George T. Lukemeyer, Indianapolis
Grievance
 Richard B. Schnute, Indianapolis
Indiana Medical Foundation
 Frank B. Ramsey, Indianapolis

ISMA KEY STAFF

Richard R. King, Executive Director
 Adele Lash, Director of Operations/Communications
 Mike Abrams, Director of Marketing/Legislation
 John Wilson, Director of Administration
 Ronald Dyer, General Counsel
 Susan Grant, Executive Assistant
 Richard Ryan, Field Services (Northern)
 Bob Sullivan, Field Services (Central)
 Janna Kosinski, Field Services (Southern)
 Barbara Walker, Reimbursement Coordinator
 Marvona Welsh, Reimbursement Coordinator
 Tom Martens, Members Health Insurance
 Tina Sims, INDIANA MEDICINE



To Plan The Most Successful Conference Possible, You Really Should Check All Your Options.

The University Place Conference Center & Hotel offers all the options you should expect to make your conference a success. And, probably a few things you'd never expect. So, if you'd like a free information packet on the features listed, call **800-627-2700**. Because once you've checked us out, you won't even consider any other location as an option.



University Place

Conference Center & Hotel

On the Campus of Indiana University • Purdue University
I N D I A N A P O L I S

800-627-2700

(In Indiana 317-274-3196)

Features	<i>University Place</i>
278-room AAA 4-Diamond hotel	✓
Resources of two major universities	✓
338-seat auditorium with sloped seating	✓
Unmatched A/V capabilities	✓
Award-winning restaurants	✓
385-car underground garage	✓
Full-time A/V staff	✓
Turnkey Conference Planning Service	✓
Skywalk to Olympic-class sports facilities	✓
Thirty soundproof meeting rooms	✓
Two tiered meeting rooms	✓
Videoconferencing	✓
Computerized audience response system	✓
Continuous refreshment service	✓

IU dean examines

Bob Carlson
Indianapolis

There are now more physicians in Indiana and in the United States than ever before. In fact, the increase in the number of physicians has been greater than the increase in population. In 1980, Indiana's population-to-physician ratio was 867. In 1990, it was 671. Nationally, the 1990 ratio was 435 people for every physician.

And yet, according to the 1991 Indiana Physician Profile, prepared under the auspices of the Indiana Academy of Family Physicians, only four of Indiana's 92 counties have population-to-physician ratios of less than 500:1. On the other end of the scale, nine Indiana counties have population-to-physician ratios greater than 3,500:1, which means they are classified as Health Manpower Shortage Areas. In Indiana and across the United States, the areas on the short end of the scale tend to be rural.

The current decline in the number of primary care physicians can be examined by looking at trends in the medical education system. For example, medical school graduates nationwide who choose primary care fields for residencies declined from 37.3% in 1981 to 23.6% in 1989. Nationwide, the percentage of graduating seniors who express a preference to practice medicine in large and medium cities and their suburbs has increased significantly from 1981 to 1991, while the percentage wishing to practice in small cities and towns and rural areas declined significantly.

Walter Daly, M.D., dean of the Indiana University School of Medicine and director of the I.U. Medical Center, offered his perspectives on the primary care

issue during a recent conversation with INDIANA MEDICINE.

Dr. Daly is himself a graduate of the I.U. School of Medicine. After completing post-doctoral training as a U.S. Public Health Service Research Fellow at I.U. in Indianapolis, he served as instructor, professor, director of the cardiovascular and hypertension research centers and chairman of the Department of Medicine at the I.U. School of Medicine. He was appointed to his current positions in 1983. Dr. Daly is active in numerous national, regional and local professional, academic and civic organizations.

IM: What has been the trend in health manpower over the past decade, in terms of supply and demand?

Daly: Well, the number of physicians in the country has increased hugely, all across the country and including in Indiana over the past decade. Twenty or 30 years ago, the presumption was that there were too few physicians and that something significant had to be done about it. At that time, quite a number of new medical schools were created, and the existing ones enlarged their classes. Here in Indiana, we virtually doubled the class size. Further study of this, published sequentially in the 1970s, indicated that there was going to be an excess of physicians all across the country, with the exception of certain specialty areas, primarily family medicine, perhaps psychiatry.

Over the last few years, there's been little to change the overall thinking about the numbers, but there's been considerable re-thinking of some aspects of it.



primary care issue

Mainly, the geographic distribution of physicians is not working out with what would be optimal numbers, nor has the specialty distribution worked out in a way that is entirely desirable. I think what that really means is that the overall analysis may have been reasonably correct but certainly the geographic and specialty distribution has not worked out the way one would have wanted it.

IM: How has the geographic and specialty distribution developed?

Daly: Well, with respect to geography, the younger physicians tend to gravitate to the metropolitan areas. Now this isn't absolute, but the consequence is that there are greater numbers of physicians in the metropolitan areas than in the rural areas. This resulted in a maldistribution geographically. And with respect to the specialty distribution, younger graduates have tended away from the primary care disciplines.

IM: Any thoughts on why that might be?

Daly: First of all, there is a very real reimbursement issue. In some countries, for example, there

is no reimbursement differential. In others it's relatively small. Here it may be anywhere from two-to-one to a five- or six-to-one differential.

Then, those who do primary care experience a great deal more regulatory hassle. If they're seeing, for example, 100 patients a week, and there's a certain amount of paperwork that has to be done for each one, then that's 100 times whatever the factor is. If on the other hand, an individual is doing a limited number of procedures a week, then the number of those encounters with the regulatory process is far less.

“There are many fields today that are high-tech oriented with perfectly fascinating kinds of opportunities, while the primary care people have less of that and consequently do not have that attraction.”

Then there are lifestyle issues. Primary care is one of prolonged contact with patients whose problems may persist, while in many other disciplines the contact is more episodic and consequently the enduring responsibility is not as continuous.

Then, I suppose there's the issue of the need for primary care in many remote areas, and I don't mean remote like might exist in some parts of the country, but

with respect to Indiana, there are areas somewhat more remote than a metropolitan area. That produces different kinds of limitations on how people can spend their time.

On the medical support issues, people tend to function in a much more independent manner and without the group support which comes from multi-specialty presences. And that is appealing to some and not appealing to others and I suspect over the last decade it's become apparent that those who are not enticed by that outnumber those who are.

Then I think there's the issue of technology and the attraction of technology. There are many fields today that are high-tech oriented with perfectly fascinating kinds of opportunities, while the primary care people have less of that and consequently do not have that attraction.

There's also the issue of what some would perceive as a manageable versus a less manageable information base. The narrower the specialty, the narrower the information base, the broader the specialty, the broader the information base. With which of those does a particular individual become comfortable? Younger physicians tend to be more comfortable with a more manageable information requirement.

I think those sort of cover the issues. The comments I'm making are obviously generalizations and can't be applied specifically to any given individual. Physicians are not all of one mind about this sort of thing. So what I'm giving you is perhaps superficial but at least [these are] my observations of general reactions.



IM: What is the current availability of primary care physicians in Indiana?

Daly: Well, there's very little information about that. The best information available has emerged from a recent analysis of the problem that was conducted by the Indiana Academy of Family Physicians and Indiana University, through its School of Public and Environmental Affairs and the Department of Family Medicine. This maps out the fact that over the last decade there's been a very sizable increase of primary care physicians in Indiana, but that there are also many areas, more so rural than metropolitan, although some metropolitan areas exist, where there are still too few. So the answer is, aggregate numbers are getting better [but] there is a geographic maldistribution between metropolitan and non-metropolitan in Indiana. Same thing's happening all across the country.

IM: Where geographically would you say is the need for primary care physicians in Indiana most acute?

Daly: Well I don't want to give you the names of particular counties because that might be arguable, but in general, I'd say southern Indiana, particularly southeastern Indiana and also certain areas of northwestern Indiana. But then you can go across the state and find spots everywhere. And in focusing on the rural areas and dismissing metropolitan, I think a very real mistake can be made because the inner city areas in all large cities in the country have the same problem as the

rural areas.

IM: Would you say for the same reasons?

Daly: No, I'd say for different reasons. The issues of isolation don't apply. But the issues of lifestyle and reimbursement and hassle and information base do apply. And furthermore, some of the inner city areas may not be as pleasant to live and work in.

IM: Has the shortage of physicians in some of these rural areas been a more serious trend in recent years?

“As far as the educational enterprise is concerned, we've been tooling up to cope with this problem for about four years now ...”

Daly: It's certainly been a problem for the last 20, 25 years and I think it's receiving a great deal more attention at this particular time than it has for some years. I think people today are more vocal in their expression of flaws than they were a few years ago.

IM: Would you please discuss some of the options that are being considered to correct the maldistribution between metropolitan and rural?

Daly: I would say, first of all, your question must relate to options that education has, this

medical school or other medical schools, and then other kinds of options that society in general or government or communities may have. As far as the educational enterprise is concerned, we've been tooling up to cope with this problem for about four years now, and I think have made some very substantial educational changes that should do what we can to address the problem. Primarily, those are intended to increase the fraction of our graduating class that's interested in primary care.

Other steps that we would like to take depend upon certain community involvements and finances. I would like to establish one or more rural education centers where our medical students and interns and residents could participate in medical education in a rural setting and hopefully then become attracted to that. But that doesn't really address some of the other issues that attract people to a practice of that kind.

I think of the other steps that really ought to be taken, the primary one would be a very generous forgivable loan/scholarship program for medical students that would take the form of a loan that would then be forgiven if they enter this kind of practice in the kinds of settings that we're talking about. I think that could be very, very helpful and very substantial. I think that's a role that state government or the federal government, because it's a national problem, could play very successfully. On the other hand, I think communities also might play a role in that.

Then I think there are other issues that communities and community hospitals can play in terms of facilitating and establish-

ing practices in various areas. I think that's already going on but perhaps can be done in a more coordinated manner. Ultimately, the issues of support and reimbursement become important. Not only reimbursement in the quantitative sense, not only how much money people receive, but the regulatory processes that various payors impose in order to approve payments. Some of our graduates who have gone to rural settings to practice have left them over this issue and over the issue of Medicare, for example, which reimburses them for their office visits at a rate that is less than what's necessary to pay the expense, let alone any kind of personal income.

IM: IU has added a month-long family practice rotation to its third-year medical school curriculum?

Daly: Yes. This was started last June.

IM: Is it too early to evaluate results?

Daly: No. We think it'll work very well. But let me explain how it works first. I mentioned awhile ago that we'd started tooling up for this problem about four years ago. This is not a simple thing to do. It requires, first of all, the appropriate faculty, and we didn't have them, so we had to acquire them. And second, it's not something you do here on this campus, so it required vast organization of lots of different people across the state to carry this off. It's something you couldn't do immediately.

The third-year students are

placed in a month-long situation using the state's family medicine residency programs as a home base. Students go to those sites, scattered across the state, [including] here in Indianapolis. They spend one day a week at that site, where they have various didactic programs, and then spend the rest of the time in the offices, or at least with nearby individual family physicians. So they may be in a nearby community, rural community, or they may be in the city where their family medicine residency program is. And they participate in the physician's patient care activities there. It works very well. The physicians who have been involved in this, have been very enthusiastic about it and so have the students. And we have every reason to believe that it will greatly increase our graduates' attraction to primary care. We don't have the exact numbers yet because the students who first experienced this will be graduating next year. The expectation is that it will about double the percentage attracted to family medicine.

IM: Are there any other things that IU medical school is doing to encourage medical students to choose primary care?

Daly: Well, we're saying it's important. I think that students will come to understand that it's an important opportunity. But fundamentally, they have to have experiences that are attractive to them and I think we're preparing that. That's what this third-year course is about. And they also have to see that communities and society value those kinds of people, those kinds of physicians.

And I think thus far, that has not really come across.

IM: I'd like to focus specifically on the issue of medical school debt and to what extent that has been a factor in affecting medical students' choice of specialties.

Daly: That's a very difficult question to answer, and it's been studied on numerous occasions with conflicting results. But it makes sense that there should be a close relationship. Sometimes it's difficult to find out quantitatively how close the relationship is. Across the country, medical students graduate from medical school with an average debt of more than \$50,000. With ours, about 70% have an identifiable debt. And the reason I'm defining it that way is, we know about the 70% because they're processed through our financial aid office. The other 30% may or may not have debt. But of the 70% that have an official debt, the average is about \$47,000 when they finish.

Now, two issues. First of all, much of that debt is related to federally guaranteed loans that have previously had deferral on the time payments have to start, until the residency period is over. Legislation is now changing, which makes them liable for initiation of repayment while they're still in their educational process, still in residency. That will be very bad because it makes the debt come due at a time when they really do not yet have the income to deal with it. It compounds the pressure of debt. If they're going to have a debt, they may have to borrow from another source to pay the debt during the time of their residency program.

So they may finish their residency programs with yet larger debts. Then they have the question, what kind of practice am I going into, where I'm going to support that debt and pay it off in a reasonable period of time. And then comes the question of how much income do I need to do that. Then they may be driven to higher income kinds of specialties, which then compounds the primary care problem.

IM: What is the impetus for this legislation that you just cited?

Daly: The legislation that relates to this kind of loan is not specifically medical student type loans. It's all educational loans. There's been great concern in many segments of the public and in Congress that people who receive these educational loans are not paying them off. Well, in truth,

the medical student default rate is very, very low. There are problems in other educational fields. However, the same statute covers everybody.

IM: Can you discuss the issue of women medical school graduates choosing to enter primary care instead of more specialized fields? Are there any trends or statistical ways of looking at that?

Daly: Well, my basic answer to that is no. My reason is that the numbers of women who are going to medical school has been increasing so rapidly and their attraction and their interest in a variety of different fields has been increasing so rapidly that I don't really think that generalization describes the situation.

Traditionally, women primarily went into pediatrics. And

there are still a lot of women going into pediatrics. But they go into everything now. I think it'll take a few more years for it to settle out to find out what the real distribution is.

There are arguments that would say there will be fewer women going into primary care because of the lifestyle demands placed on physicians who do that kind of work. On the other hand, that may be exactly wrong. I just think it's too early. But we see our women graduates going into everything. Thirty-eight percent of the class that started this last fall was women. And just a few years back it was a far smaller percentage. With all that kind of change going on, I don't think we know how it's going to settle out. □

This interview was conducted by Bob Carlson, a health care communications consultant in Indianapolis.

The Science of Healing...The Art of Caring

Exceptional professional and recreational choices are yours in West Michigan. Due to rapid growth, the Butterworth Health System offers attractive professional positions in its 530 bed tertiary care teaching hospital, 4 affiliate hospitals, and 7 Med+Centers. Positions are available in pediatrics, medicine/pediatrics, internal medicine, surgery, orthopedic surgery, otolaryngology, radiology, and OB/GYN. Opportunities include group practice, partnership, and solo or salaried urgent care and outpatient practices.

Choose Butterworth Hospital in Grand Rapids, which serves a population of 700,000, plus a 13 county referral area, or a small community or rural environment at one of the affiliate hospitals. Grand Rapids is West Michigan's cultural, educational, and economic center. With Lake Michigan only 30 miles away and numerous forests and parks nearby, there are ample opportunities for recreation and entertainment. Listed below are a few of the many opportunities available.

• **Family Practitioner/Outpatient Practice** BC/BE family practitioner full-time, 4 1/2 days, Monday through Friday. Established satellite outpatient practice, offering continuity of care, no call and regularly scheduled hours. OB, call, and hospital practice optional. Full benefit package, competitive salary with quarterly and year-end bonus. Opportunity to work additional hours in Med+Center, if desired.

• **Family Practitioner/Private Practice** Three well established and thriving group practices at Butterworth Hospital desire to expand by adding an additional BC/BE family practitioner. Join existing groups consisting of 2 - 5 physicians, OB optional. Desirable call schedules, competitive salaries and benefit packages.

• **Family Practitioner/Urgent Care Center** Join the growing field of ambulatory care, Med+Center BC/BE family practitioner needed to provide medical services to patients on a regularly scheduled basis. No call schedule, flexible hours, excellent compensation and benefits.

• **Family Practitioner/Primary Care Clinic** BC/BE family practitioner or internist needed for a large, primary care medical and dental clinic in Grand Rapids. The clinic is managed by Butterworth Ventures, the largest health care system in West Michigan and funded by private donations and a federal grant. Staffing includes 2 family practitioners, a pediatrician, nurse practitioner, medical director and support personnel. This is a salaried position with a competitive compensation and benefit package and 1 in 5 call schedule.

• **Internal Medicine/Faculty Position** Board certified general internist with teaching and clinical skills needed to join dynamic full-time academic faculty for internal medicine residency. Responsibilities include direct patient care in faculty practice, supervision and teaching of residents and students in both outpatient and inpatient settings. Competitive salary and benefits. Protected time is available for research and teaching.

• **Internal Medicine/Emergency Medicine** Immediate opening for a BC/BE internist with emergency medicine experience. Join a rapidly growing group of internists who cover the Emergency Room and in-house patients at United Memorial Hospital in Greenville, Michigan (1 hour from Lake Michigan and 35 miles from Butterworth Hospital). Flexible hours, no call, excellent reimbursement and benefit package.

• **Multi-Specialty Outpatient Group: Family Practitioner, Med/Peds, Internal Medicine, Pediatrician**

Dynamic 7 physician multi-specialty group providing outpatient care at United Memorial Hospital seeks additional physicians. Full-time position, 4 1/2 days Monday through Friday with additional hours available in the urgent care center or Emergency Room. Located in Greenville, Michigan (1 hour from Lake Michigan and 35 miles from Butterworth Hospital). Call and inpatient care is optional with opportunities available to do procedures in the hospital or office. Competitive salary and full benefit package including malpractice

**For information about the above positions, please call or write to
Nancy Martens, Manager Medical Staff Placement 1-800-788-8410.**

**Butterworth Health System, MC 73, Nancy Martens, 100 Michigan NE,
Grand Rapids, Michigan 49503**

Recruiting doctors: Big job for small towns

Betty White
Indianapolis

Suppose you have just spent thousands of borrowed dollars and four years in college, four years in medical school and three or more years of residency training to become a primary care physician.

Would you go looking for a practice opportunity where you would (literally) get up with the chickens, work long hours and make less money than your fellow graduates?

This is the predicament facing rural hospitals all over the country: How to attract primary care physicians who may not be interested in country life.

But first a little history

In the 1970s, state and federal funds were allocated to encourage medical students to enter primary care residencies and then practice in underserved areas. The beneficiaries of this largess were to be populations in the inner cities and rural areas.

In the meantime, medical schools were turning out physicians in record numbers.

By the mid 1980s, there was one physician for every 500 Americans, according to the *Journal of the American Medical Association*, and the number of physicians was growing three times as fast as the population.

Government policy makers projected a physician surplus and cut appropriations – assuming that the overall increase of physicians would be reflected across

the board.

They were wrong.

Instead, the number of medical graduates who chose primary care has steadily decreased, and in rural Indiana, the shortage is critical.

In fact, nationwide, we are not graduating enough primary care physicians to replace the 24,000 family and general practice physicians who are now over 55 years of age.

Urban life preferred

According to the Association of American Medical Colleges: In 1991, only half as many medical students preferred rural practice compared to those surveyed in 1981. Of the 11,000 students queried, 88.7% want a population of more than 10,000. Slightly more than 26% of senior medical students preferred rural in 1981 – only 13.5% in 1989.

Many factors are involved in the declining numbers of primary care physicians and the resulting impact on rural communities, not the least of which are lifestyle and income. Debt-ridden medical school graduates often choose more lucrative specialties.

Addressing the members of the Indiana Commission for Higher Education, Frank Learned, chairman of the Indiana Hospital Association Board of Directors, described “a rush to what are perceived as glamorous and lucrative specialties.”

Recent graduates also are concerned about the amenities of life. If they are married, family issues are important. Are there career opportunities for a spouse?

What about schools, cultural and recreational facilities?

Competing with the cities

How do rural communities compete with the lure of the cities? To find out, we interviewed a number of rural Indiana hospital administrators.

All the administrators we talked with agree on the following points:

- Have a game plan – anticipate retirement and other factors that affect staffing.
- Allow lead time for finding and recruiting to replace staff.
- Create a competitive incentive package.
- Learn as much as you can about the candidate and the family before you interview them.
- Plan their visit based on your understanding of the family's needs.
- Enlist the help of your staff members and their spouses.
- Be creative. Two administrators we talked with have produced videos that have proved to be effective.

John Taft, administrator at Daviess County Hospital in Washington, Ind., reflects, a bit wistfully perhaps, that before World War II three-quarters of all physicians were primary care physicians. But after the war there was an “explosion of medical knowledge that led to more specialization.”

“On the north fringe of Indianapolis, there is a surplus of primary care physicians. Still, all across the country there really aren't enough primary care doctors.”

To encourage more medical students to choose primary care as their specialty, Taft believes there should be mandatory programs that require residents to take a turn in a rural hospital.

Encourage good students in your community to go to medical school; then keep track of them and offer support when you can. And of course, be sure to lock in your protegee before anyone else does.

Taft, who has recruited five physicians over the past 11 years, still needs 10 more. To help him sell a good candidate on settling down at Daviess County Hospital, Taft has worked with an advertising firm to develop a recruiting video.

"All the parts are played by our physicians and their wives. We talk about our area and what it's like to live here and work here. It's been successful for us."

George Poor, executive director at Cass County Hospital in Logansport, runs an aggressive recruitment program. "We are leaders in our area, we have no debt, we offer a lot of benefits. We craft very favorable contracts for our physicians – salary and a minimum draw, and startup expenses if the physician stays a certain length of time."

Poor makes a special effort to attract spouses – wives only, so far. "Our area is not as fast-paced as you might find elsewhere. Our physicians don't have to work six-and-a-half days, so there's more time to spend with the kids. There are no long commutes.

"On the other hand, we're

only an hour-and-a-half from Clowes Hall, two hours from Chicago, and I can drive to Keystone at the Crossing [a shopping and restaurant complex in Indianapolis] in one hour and 10 minutes flat!"

Perhaps most appealing of all, "the air is clean, you can grow tomatoes without fertilizer, and you don't have to lock your door," Poor says.

"We're not unique," says Jonas Uland, administrator at Greene County Hospital in

ety says they ought to have an 8-to-5 job, and that's what they want."

This is a mentality that complicates Uland's efforts. "We don't have a lot of group practices, just single doctors dispersed around the community. There are no partnerships to help cover calls."

To alleviate that problem somewhat, the hospital has expanded emergency room services for 24 hours with in-house physicians.

Incentive packages are tailored to fit the person. They include office space, generous guaranteed take-home pay, and other perks. Uland is wary of the candidate who wants the biggest dollar. "He's coming just for the dollar aspect."

Todd Stallings, administrator at Clinton County Hospital in Frankfort, has also had good results with a recruiting video for physicians and technical staff.

The video has been used to good effect by the Chamber of Commerce and a local bank as well as the hospital. Like all the administrators interviewed, Stallings is very sympathetic to the new physician's enormous debt, and the fact that the rates general practice physicians can charge are a great deal lower than most other specialties.

For example, the general practice physician might spend 24 hours with a patient to bring him back to health and receive \$200. Other specialists will complete a 30- to 45-minute procedure and collect \$2,000.

Stallings has also noted that

Like most of the administrators we talked with, Uland sees today's general practice physicians as a different breed.

Linton. "We're always short-staffed. We've just lost our obstetrician ... the old doc has gone out of business."

Half of the Greene County Hospital medical staff are turning 70, so the pressure is on to sign up replacements. Uland has recruited four physicians in the last eight years. Recruiting one physician every two years seems to be a pattern among the administrators interviewed for this article.

"We're feeling the pinch," says Uland. "There are fewer general practice physicians, and most of them have completed residence in larger cities. They may be happily settled with contacts that cause them to stay."

Like most of the administrators we talked with, Uland sees today's general practice physicians as a different breed. "Soci-

physicians are more mobile than they used to be. He aims to keep members of the staff at least five years, but he is not immune from raids by other hospitals attempting to recruit staff.

Advice from a recruiting pro

For the viewpoint of a professional recruiter experienced with the medical community, we called on Patti Quiring, of Quiring Associates, Inc. in Indianapolis.

Noting that most primary care physicians choose to practice in an

urban setting, Quiring adds that rural facilities have to pay extremely high income guarantees over a period of years to offset the physician's concern about quality of life.

A typical example might be as follows:

Dr. X has an \$80,000 income guarantee for the first year with a partnership track of two to three years in a metropolitan area of 750,000 people.

The same Dr. X has a \$125,000 income guarantee over three years

with partnership at the end of a \$50,000 loan repayment from a rural community of 15,000 people over a three-year period.

"Many rural communities are giving terrific incentives to attract a doctor away from an urban or metropolitan area where the quality of life is perceived as better by the doctor and the members of his or her family." □

The author is an Indianapolis freelance writer.



**SAFE
EFFECTIVE
CONVENIENT
ECONOMICAL**

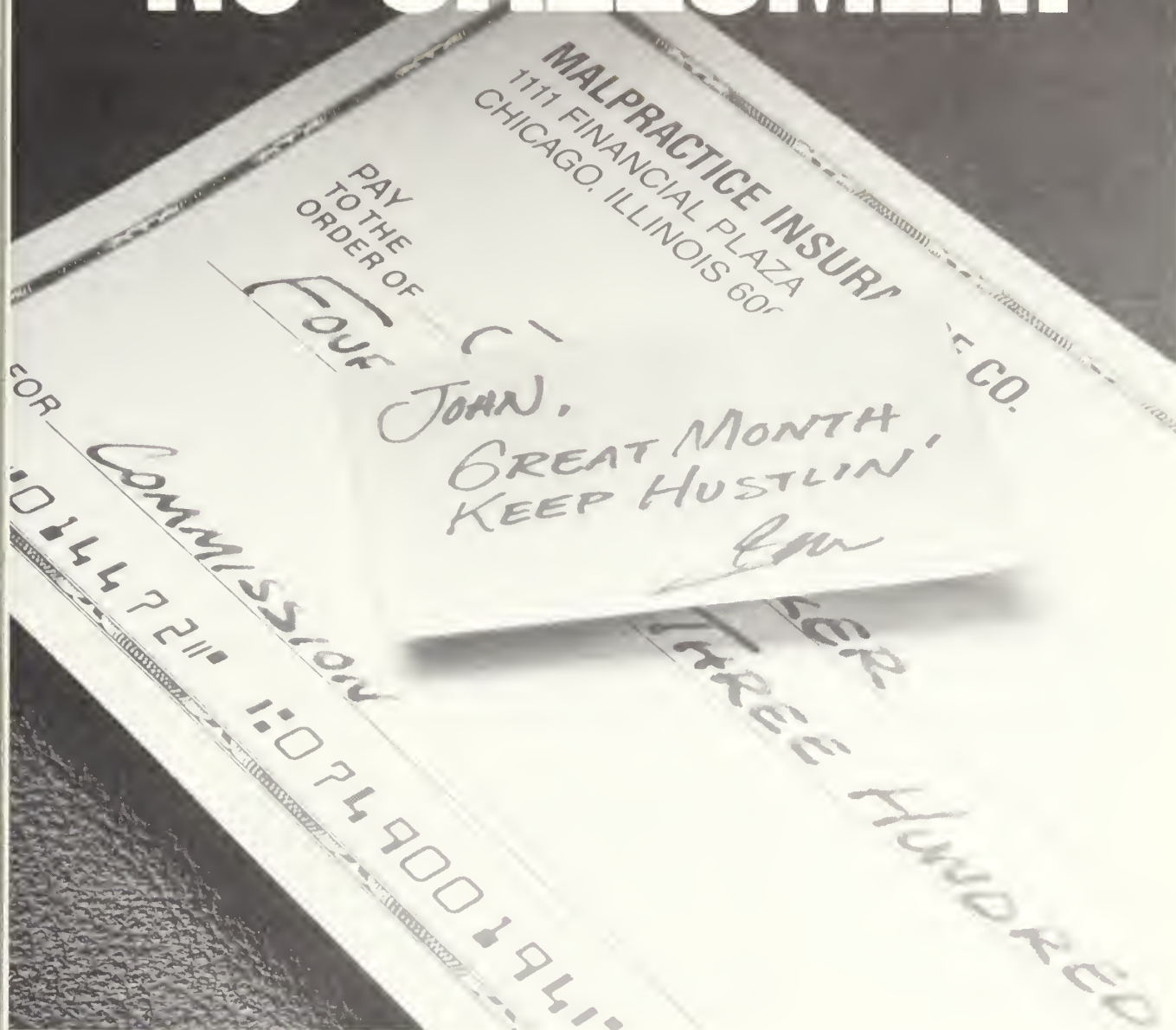
Mono-Gesic[®] Tablets
(750mg Salsalate)

**A well tolerated
Salicylate Therapy**



C[®] CENTRAL PHARMACEUTICALS, INC.
SEYMOUR, INDIANA 47274 USA
Quality Pharmaceuticals Since 1904

NO SALESMEN.



A salesman's primary concern is to sell. That's precisely why we don't employ any. Our general agents make no commission, and work exclusively for us. So they spend less time selling, and more time advising, informing

and preventing problems for their clients. Their success isn't measured by how well they sell. But by how well they serve. For a different approach to professional liability, call your Medical Protective general agent today.

MEDICAL PROTECTIVE COMPANY

Vernon E. Hoover, H. Jere Frey, Michael W. Kinzer
6100 North Keystone Avenue, Suite 237, P.O. Box 20576, Indianapolis, IN 46220 • (317) 255-6525

Robert B. Newell, J. Barton Lyon
Suite 240, 2260 Lake Avenue, P.O. Box 5174, Fort Wayne, IN 46895 • (219) 422-4783

Rural physicians have chance to make a difference

Tina Sims
Managing Editor

Rural physicians may have fled from crowds, traffic jams and impersonal medicine, but they have not dodged the problems of Medicare reimbursement, government interference and 60-hour weeks.

At least that's the consensus of the rural physicians interviewed by INDIANA MEDICINE. While most of them agree that small-town living may not be the lifestyle for everyone, physicians who have chosen rural medicine generally are happy with their decision.

They list a variety of reasons for their satisfaction.

"I like being responsible for all the things that concern a patient's health," says Paul Daluga, M.D., who has practiced in Linton for six years. "It's nice to have the whole gamut of experience."

Citing the fact that he is able to treat a range of illnesses, including AIDS, Dr. Daluga says his rural practice gives him a much broader picture of medicine.

Stephen R. Myron, M.D., a Portland family practitioner, echoes those sentiments. His rural practice gives him the opportunity to be a "more complete physician" and to perform more procedures than his colleagues in urban settings.

That occupational diversity also appeals to Thomas B. Smith, M.D., a Flora family practitioner. Dr. Smith enjoys the fact that he can perform treadmill tests and gastroscopies and set broken

bones, procedures that in larger cities would be left to specialists.

Dr. James P. Beck, a Washington, Ind., internist, feels the same way. He says, "I do all sorts of things I know I wouldn't be allowed to do in a larger community."

Another often-cited benefit of rural medicine is the closer relationship between physicians and patients. "You get to know your patients quite well. You know who your patients are and that helps in treating them," says Thomas A. Barley, M.D., who has practiced in North Vernon for eight years.

Dr. Myron, who manages a dual career as a physician and as a farmer, expresses similar sentiments. He likes "having that more complete relationship with

people" and enjoys being his patients' friend and fellow churchgoer. In his case, he is especially familiar with many patients since he grew up in Portland, on a farm. There never was much doubt where he would settle down. "It was more important where I practiced than what I practiced," he says.

Dr. Myron has combined his two careers in another endeavor – as a regular guest columnist for *Farm Journal*, a national business magazine for farmers and ranchers. His column, "Dr. Myron's House Calls," first appeared in the January issue.

Since many rural physicians do make "real" house calls – at least occasionally – and become friends with their patients, they also have another edge in treating



Stephen R. Myron, M.D., of Portland listens to the speakers at the ISMA/IMPAC seminar in Indianapolis. Dr. Myron, whose family practice office includes The Center for Wellness, also is a farmer in Jay County.

their patients. Sjoerd Roggeveen, M.D., of Kentland says he has more insight into their personal lives as a result of having been in most of his patients' homes.

Slower pace appealing

Michael O. Mellinger, M.D., values the "less hectic and more laid-back lifestyle" and the more intimate contacts developed with patients in a rural community. He grew up in LaGrange, where he has practiced for 27 years.

That less hectic environment means less traffic to fight and fewer crowds, factors that several physicians mentioned in their preferences for the rural life.

"You have to want to live a quieter life," says Susan K. Pyle, M.D., who has practiced in Union City, her birthplace, for 22 years.

Recognition in the community could be a problem for those not accustomed to small-town life, but most of these physicians know that a patient who stops them in the hardware store on Saturday afternoon to ask them about a back pain is all part of a day's work. "If personal contact bothers you, you don't want to be in a small community," says Dr. Beck, who has practiced in Washington since leaving Rochester, Minn., in 1975. He was attracted to the area during trips to visit his wife's family.

Still, becoming a familiar face about town sometimes can take a while. Alben Shockley, M.D., of Rockport, a town of 2,200 near the Ohio River, recalls the woman who approached him while he was shopping for potting soil at the grocery store and asked him if he worked there. Indiana's more favorable malpractice climate and the opportunity to work in a rural area helped lure Dr. Shockley to



Thomas B. Smith, M.D., is a family practitioner in Flora, described as "The Garden Spot of Indiana - Where You Will Meet Friendly People" on a sign seven miles east of town.

Indiana from Kentucky about two years ago. Dr. Shockley, who grew up in Fountain Run, Ky., - population 350 - appreciates the slower pace of life, patients who seem more appreciative of his services and the chance to be his own boss.

Being his own boss appeals to Dr. Daluga, too. "If you're smart about it, you can control your practice," he says.

Dr. Daluga believes he has succeeded in doing that. "I do what I need to do" to care for my 4,000 patients, he says, and realistically he knows that means he is on call 24 hours a day, seven days a week. Yet he also knows that

physicians will succeed in a small-town setting only if "they don't try to be all things to all people." He tries to maintain some privacy in his personal life and says his patients understand that need. "They know a guy needs a break," he says.

Rural communities are good places to raise children, many physicians say. Dr. Daluga, for example, grew up in Indianapolis but says he didn't want to raise his children there. He became interested in small towns when his summer job during high school took him to rural areas to install fences. "It's a much better place to be a family person," he

says of small towns.

Since the original interview with Dr. Daluga was conducted, he has announced he is leaving his practice in Linton. Effective Aug. 10, he will be a physician for the federal prison in Terre Haute, but will continue to live in Linton. He is looking forward to spending more time with his family once he begins his new 40-hour-a-week position, which requires no weekend duty. Dr. Daluga said the benefits of the job, coupled with the fact that he will not have to spend several thousand dollars to comply with the new OSHA Regulations on Bloodborne Pathogens, influenced his decision.

Drawbacks cited

Physicians can diagnose the illnesses of rural medicine as easily as they can cite its healthy points.

Probably the most frequently mentioned disadvantage is the discrimination these rural physicians feel as a result of Medicare reimbursement inequities. Most physicians say the new resource-based relative value scale (RBRVS) has not improved their reimbursement. Although the RBRVS was designed to increase reimbursement to primary care physicians, rural physicians say they are still paid less than their peers in urban and metropolitan areas.

"Our government involvement has been a joke," says Dr. Smith. Recently-implemented federal regulations, including the RBRVS, the Clinical Laboratory Improvements Amendment and the new OSHA regulations, have not helped family practitioners, he says.

"The government routinely discriminates against people in rural communities," says Dr. Myron. He questions the government's rationale in dis-

Physician prefers city practice

Rural medicine is not for everyone, as Gerald L. Braverman, M.D., found out 15 years ago.

That's when Dr. Braverman left his practice that served Kendallville, LaGrange and Angola and came to Indianapolis, where he has been since. He had worked in the northern Indiana area for two years.

"I just felt I was jack-of-all-trades and master of none," he says of his rural practice. "I wasn't practicing the kind of medicine I wanted to practice."

He said the lack of readily accessible specialists meant the medical care was adequate, "but not as good as if you concentrated in one area." The rural hospitals were not sufficiently equipped, he believed. He recalls the time a patient was having a heart attack, and the only heart monitor in the hospital was tucked away in a closet and literally had to be dusted off before he could use it.

On the positive side, the people were friendly and appreciative, and the patients and nurses showed him "a lot of respect" – perhaps too much respect, he says.

He also says that his rural practice was in some ways "the good old days" because he had the opportunity to perform a variety of procedures.

Dr. Braverman, however, says he enjoys his current practice environment, in an internal medicine group practice on the Indianapolis southside. □

counting the fees paid to physicians in rural towns – the same places so in need of physicians.

Dr. Beck objects to the fact that he is paid less in his colleagues in urban areas yet his credentials are the same. Why does such a colleague receive \$10 more per visit than I do? he wonders.

Isolation was mentioned as another disadvantage. "It would be nice to have a colleague to talk to," says Dr. Shockley, whose patients come from all over the county and from Kentucky.

"It can get pretty lonely out there," says Dr. Beck.

Both Dr. Beck and Dr. Shockley work in counties designated Medically Underserved Areas, according to a document

titled "The Health of the Rural Population" from the Indiana State Department of Health. Medically Underserved Areas are defined as areas determined by the federal government to have inadequate access to health care as determined by the Index of Medical Underservice (IMU). The IMU is the sum of the weighted values of four indicators of unmet health care needs in an area: percent of population below poverty, percent of population age 65 and older, infant mortality rate and number of primary care physicians per 1,000 population.

Many of the physicians interviewed work in counties that they say need more physicians. They work anywhere from 60 to 75 hours a week. Some are so busy

they are either not accepting new patients or are restricting the number of new patients. "There aren't enough of us to go around," says Dr. Beck.

In Flora, for example, Dr. Smith and his partners are sharing an increased work load as the result of a colleague's recent move to Indianapolis. Dr. Smith says his group probably will not replace the departing physician.

"It is well-known it [rural medicine] is harder work for less pay," says Dr. Roggeveen, who moved from Canada to practice in Newton County.

Distance from medical technology, from specialists and from the amenities of bigger cities, such as restaurants and cultural and athletic events, are other disadvantages mentioned by some physicians.

For example, because Carroll County does not have a hospital, Dr. Smith has to send his patients 40 miles away, to a Lafayette hospital. He is considering dropping his hospital practice, however, because of problems with reimbursement.

Dr. Shockley's patients must travel to Owensboro, Ky., 15 miles away, or Evansville, 27 miles away, to see a specialist or undergo a test such as a MRI scan.

Dr. Pyle laments the fact that patients sometimes cannot have tests done as promptly as she would like.

"It'd be comforting to have a

specialist around all the time," says Dr. Mellinger. However, specialists do visit LaGrange, and magnetic resonance imaging is 50 miles away, so he does not feel hampered by a lack of technology.

"I think we have all the technology we really need," says Dr. Beck. He does admit, however, that "if you want the Mayo Clinic, we're going to fall short."

Call coverage can pose another problem. Physicians without nearby physicians to help with coverage have to be more flexible, says Dr. Pyle. When she

realized that no one would be available to take calls on a day she once planned to attend a meeting in Indianapolis, she had to cancel her plans.

Despite the drawbacks, most rural physicians are not leaving for the bright lights of the big cities. Many feel, as Dr. Barley does, that "the need is so great" in rural areas that they have a chance to make a difference.

And many agree with Dr. Mellinger, who says being a rural physician is a "wonderful way to go through life." □



Thomas A. Barley, M.D., is an internist in North Vernon, where he and his wife bought and are remodeling "the oldest house in town."



ARNETT CLINIC

Lafayette,
Indiana

About the Multispecialty Medical Group

Arnett Clinic has served Tippecanoe County and surrounding counties in Mid-North Central Indiana since 1922. Arnett physicians introduced the area's first dialysis service, performed the area's first open heart surgery, and developed the community's first heart catheterization laboratory. In four outpatient facilities, over 85 specialists and subspecialists provide medical and surgical services in virtually every specialty field. The bulk of Arnett's referral patients reside within a fourteen-county area surrounding Lafayette, Indiana, with a drawing area of over 300,000 people.

Ambulatory walk-in clinics in Lafayette and West Lafayette supplement primary clinic services. Arnett Urgent Care Centers are open from 8 a.m. until 8 p.m. every day, and staff members provide diagnosis and treatment for any medical problem which does not require ambulance transport.

Arnett physicians provide hospital support services at two nearby community hospitals, Home Hospital with 365 beds, and St. Elizabeth Hospital with 375 beds. Arnett has diversified into other healthcare fields, including Arnett Health Systems (an HMO) and the corporate affiliates of Arnett Medical Supply and Arnett Pharmacy.

Opportunities

The Arnett Clinic is currently seeking BE/BC candidates: Non-invasive Cardiology, Dermatology, General Internal Medicine, OB/GYN, Orthopaedics, Pediatrics, Urology.

Practice Setting

At this time, over 85 physicians work for Arnett Clinic. One of the most practical reasons for affiliation with Arnett is the availability of ancillary staff to support clinic operations. Administrative, Laboratory, and Radiology services are available on-site, making our practice environment an integrated, comprehensive, and convenient healthcare resource center. The patient base in Lafayette stems from a balanced mix of industrial and university communities. We are an equal opportunity employer.

Benefits

Our Medical Staff members enjoy competitive salaries and a generous benefit package. During the first two years of employment, Arnett offers a guaranteed minimum salary with a production bonus. After two years of successful practice experience, shareholder status with a productivity incentive formula is available. An excellent profit-sharing and investment plan is also available.

Other benefits include health coverage via Arnett HMO or other group insurance, disability, and life insurance plans. A generous fund for continuing education is available to clinic physicians.

Community

Lafayette, Indiana is a thriving, low-crime community located in a county of approximately 132,000 people. Purdue University, known for academic leadership in the areas of engineering, agriculture, humanities, and sciences, and for Big Ten Sports, is nearby. *Money Magazine* recently identified Lafayette as one of the top 14 cities in which to live in the U.S.A.

For more information, please contact:

John C. Horner
Director of Physician Recruitment
Arnett Clinic
2600 Greenbush Street
Lafayette, IN 47904
(317) 448-8000
Toll Free Nationwide, 1-800-899-8448

Digest of health and medical laws

1992 Indiana General Assembly

The 1992 legislative session set a new Indiana record for the shortest "short" session in Indiana history. Legislators scheduled only one recess day, Jan. 20 to honor Martin Luther King's birthday, allowing adjournment on Friday, Feb. 14. The shortest previous short session adjourned Feb. 15.

Legislators managed to kill many more bills than they passed. Less than 30% of the bills passed. A total of 902 bills were introduced, 438 in the House and 464 in the Senate, while 334 passed their chamber of origin, and 268 were sent to the governor. The ISMA followed more than 200 of these bills because they were identified as potentially having some impact on health care.

Legislators heard from physicians this session. In addition to ISMA's peer-to-peer Key Contact telephone tree, the ISMA hosted "Medicine Day" at the Statehouse Jan. 15. Despite inclement weather, more than 20 physicians from across the state lobbied their legislators on important issues. The legislators appreciated the fact that physicians from the communities they represent took time to talk about important bills. The day ended with the annual ISMA/IMPAC legislative reception.

The 1992 session was successful for organized medicine. *The Digest of Health and Medical Laws* will help keep you informed about the laws enacted by the state legislature that affect you and your patients. For additional information about these laws, call the ISMA at 1-800-257-ISMA or (317) 261-2060.

Michael D. Abrams
Director of Government Relations

Jean M. Terry
Legislative Assistant

Louis M. Belch
Legislative Assistant

House enrolled acts

HEA 1004

- Authors: Gregg, Warner
- Senate sponsors: Blankenbaker, Lewis
- Allows a hospital to generate or store records electronically;
- allows a county hospital to destroy records without the approval of the local public records commission;
- makes changes to the law governing hospital board appointments.
- Effective July 1, 1992.

HEA 1006

- Authors: Goodall, Brown, S. Wolf
- Senate sponsors: Blankenbaker, Craycraft, Johnson
- Prohibits charging an organ donor or the donor's family or guardian for the costs related to an organ donation;
- makes it unlawful to sell or exchange for an item of value a human organ for use in human organ transplantation.
- Effective July 1, 1992.

HEA 1030

- Authors: Boatwright, Webber, Alderman, Kruse
- Senate sponsors: Corcoran, K. Smith, Meeks, Maidenberg
- Requires the Indiana emergency medical services commission to establish training and certification standards for the use of automatic and semiautomatic defibrillators by first responders by Jan. 1, 1993;
- limits a certified first responder's liability to acts of negligence or willful misconduct when using defibrillators.
- Effective July 1, 1992.

HEA 1035

- Authors: Kruzan, Brinkman, Day, Linder
- Senate sponsors: Sinks, K. Smith, Lawson, Zakas
- Establishes a temporary 21-member commission on abused and neglected children and their families, the purpose of which is to develop and present an implementation plan for a continuum of services to abused and neglected children and their families;
- requires one member of the commission to be a pediatrician.
- Effective Feb. 19, 1992.

HEA 1095

- Authors: Dobis, Gregg, Buell
- Senate sponsors: Johnson, Thompson, McCarty,

Maidenberg

- Allows a city option hospital tax in certain cities in Lake County;
- allows five disproportionate share hospitals to draw down additional Medicaid dollars for their facilities under a federal matching program (this section is effective Feb. 26, 1992);
- makes changes to the distribution of the Lake County innkeepers tax 75% of the 44.33% that is transferred to Indiana University Northwest must be used for the medical education program, the other 25% for allied health education (this section is effective July 1, 1992).

HEA 1129

- Authors: Leuck, Keeler, Tincher, Cottey
- Senate sponsors: Meeks, Alexa
- Imposes a tax on illegally delivered, manufactured or possessed controlled substances.
- Effective July 1, 1992.

HEA 1146

- Authors: Matonovich, Ruckelshaus
- Senate sponsors: Worman, Mrvan, Hunt, Ferree, Meeks
- Regulates premium rates for small employer health insurance plans;
- provides that a small employer insurer may not offer to transfer a small employer into or out of a plan with substantially the same benefit design unless the offer is made to transfer all small employers in that plan;
- provides for circumstances when a small group health insurance plan may be cancelled;
- requires a small employer insurer to maintain an actuarial certification;
- requires a small employer insurer to maintain for three years a complete and detailed description of the insurer's rating practices and renewal underwriting practices;
- defines small employer health insurance plan as a plan written for an employer having at least three employees.
- This act applies to all small employer health policies delivered, issued, renewed or continued after June 30, 1992.

HEA 1180

- Authors: Leuck, Fry, Howard
- Senate sponsors: Nugent, R. Young
- Requires an insurer who cancels or declines to renew a group accident and sickness policy and issues a new policy to accept for coverage under the new policy an individual who was covered under the old policy;
- prohibits the insurer from excluding or limiting the coverage to the individual or the individual's

- dependents due to evidence of insurability.
- Effective July 1, 1992.

HEA 1182

- Authors: Fry, Crosby, Nelson, Bayliff
- Senate sponsors: Harrison, Meeks
- Requires Utilization Review (UR) firms doing business in the state to be registered with the department of insurance;
- requires standards and criteria for review to be developed by a physician;
- requires all appeals of denial be reviewed by a physician;
- places the same requirements on medical claims review firms.
- Effective July 1, 1992.

HEA 1337

- Authors: Brown, Turpin, Crawford, S. Wolf
- Senate sponsors: Riegsecker, Hunt
- Establishes the drug utilization review board comprised of four physicians, four pharmacists and one person knowledgeable of therapeutic pharmacology who is neither a physician nor a pharmacist;
- requires the board to: implement a Medicaid retrospective and prospective drug utilization review program; develop criteria and standards for appropriate prescribing to be used in DUR programs; develop, select and assess interventions for physicians and pharmacists; and publish an annual report;
- requires all individual-specific information to be kept confidential.
- Effective Feb. 26, 1992.

HEA 1370

- Authors: Day, Budak, Fry
- Senate sponsors: Landske, Lawson
- Makes changes in the list of providers who are qualified to provide services under the infants and toddlers with disabilities program;
- adds services to the list of early intervention services that are provided by the program;
- establishes the same interagency board established under HB 1396 below.
- Effective Feb. 25, 1992.

HEA 1396

- Authors: Klinker, Robertson, Scholer
- Senate sponsors: Leising, Rogers, Sinks, K. Smith, Breaux
- Re-establishes the infants and toddlers with disabilities program formerly referred to as the handicapped infants and toddlers program;

- defines which disabled infants and toddlers are eligible to apply for services;
- creates the interagency coordinating council comprised of 15 to 25 members to be appointed by the governor;
- provides that at least 20% of the members of the interagency council must be public or private providers of early intervention services;
- requires the council to advise and assist state agencies that are providing services to infants and toddlers with disabilities to assure interagency coordination.
- Effective Feb. 26, 1992.

Senate enrolled acts

SEA 37

- Authors: Landske, Soards, Antich
- House sponsors: Hayes, Fesko
- Allows a court to issue an order to direct a person to take actions needed to implement the delivery of services to an endangered adult if those services are required under a protective order or an emergency protective order;
- specifies that a person is not an endangered adult solely because the person is receiving spiritual treatment in accordance with a recognized religious method of healing instead of specified medical treatment if the person would not be considered an endangered adult or in need of protective services if the person was receiving the specified medical treatment.
- Effective July 1, 1992.

SEA 91

- Authors: Worman, Hunt, Craycraft, Zakas
- House sponsors: Fry, Crosby, Denbo
- Authorizes the insurance commissioner to adopt rules to conform with federal law regarding Medicare supplemental insurance.
- Effective Feb. 19, 1992.

SEA 106

- Authors: Zakas, Weatherwax, O'Day, R. Young
- House Sponsors: Brown, Nelson
- Requires the office of Medicaid to establish a payment rate for HIV patients who are receiving special skilled or intermediate level nursing services in a health care facility;
- requires the department of health to establish a certificate of need program for the beds necessary to provide these special nursing services to HIV patients;
- continues the certificate of need program for long-term beds in the state until 1994;

- provides that if the occupancy rate for nursing home beds in a county is less than 90%, there is a presumption that additional beds are not needed;
- requires the Indiana health facilities council, when determining whether a certificate of need should be recommended to the department of health, to consider the quality of care provided by the applicant and the cost incurred to provide care.
- Effective July 1, 1992.

SEA 129

- Authors: Lawson, Blankenbaker, R. Young, K. Smith, Leising, Rogers, Thompson, K. Wolf, Breaux, Pease
- House sponsors: S. Wolf, Budak, Bowser, Boatwright
- Requires each school corporation to include instruction regarding breast and testicular cancer in its high school health education curriculum;
- requires the department of education to work with the department of health to develop the necessary educational materials.
- Effective July 1, 1992.

SEA 176

- Authors: Blankenbaker, K. Smith, Lawson, Breaux
- House sponsors: Day, Bayliff, Bailey, Budak, Wilson, Crosby
- Streamlines the health facility pre-admission screening process;
- decreases the number of people involved in a pre-admission screening team;
- creates a children's mental health bureau within the division of mental health;
- establishes a pilot program in at least three counties to look at what services are offered and could be offered to children in need of services in order that services offered "wrap around the needs of the child;"
- creates the information management committee to be comprised of 10 members (including a representative of the ISMA) and charged with studying the problems associated with confidential information relating to children and how such information should be shared (the above four sections are effective July 1, 1992);
- creates the juvenile law legislative study committee to study Indiana's juvenile laws especially regarding children in need of services and their families (this section is effective May 1, 1992);
- requires the office of the secretary of family and social services to develop a plan before Sept. 1, 1992, to move people with developmental disabilities and people with mental illness from state-operated institutions to community-based programs (this section effective Sept. 1, 1992).

SEA 177

- Authors: Blankenbaker, Gery
- House sponsors: Goble, Bayliff
- Places the community residential facilities council under the auspices of the office of the secretary of family and social services;
- provides that the division of mental health is the primary state agency responsible for planning, developing, coordinating and implementing plans and programs of residential facilities and services, including developmental and vocational services needed for people with mental illness residing in those facilities;
- adds a staff member from the office of Medicaid policy and planning to the community residential facilities council;
- prohibits a Medicaid recipient or applicant from pursuing an administrative review when questioning a determination made by the office of Medicaid;
- allows the divisions of mental health, family and children, and aging and rehabilitation services, vested with administrative control and responsibility for a state institution, to delegate operational authority to another division or office through an appropriate written agreement.
- Effective Feb. 28, 1992.

SEA 239

- Authors: Hellmann, Harrison
- House sponsors: Webber, Davis, Wilson
- Provides that in a hearing before the Worker's Compensation Board a statement of a physician may not be ruled inadmissible on a hearsay objection provided that the statement meets other requirements of law.
- Effective July 1, 1992.

SEA 255

- Authors: Server, Rogers
- House sponsors: Crawford, V. Smith
- Changes the definition of "handicapped" in the statute governing the civil rights commission so that it is the same as the definition of "disabled" in the federal Americans with Disabilities Act of 1990 (ADA);
- incorporates the employment discrimination provisions of the ADA into Indiana law and provides that a violation of these provisions occurring after July 25, 1992, is a discriminatory practice for purposes of Indiana's civil rights statute;
- requires an employer to make accommodations for a handicapped employee if the accommodations can be achieved without direct cost.
- Effective July 26, 1992.

SEA 391

- Authors: Simpson, Worman, Gard, Lawson, Pease
- House sponsors: Fry, Espich, Brinkman, Bulen
- Requires the state's insurance programs to cover breast cancer diagnostic services, breast cancer outpatient treatment services and breast cancer rehabilitative services;
- provides that these services may not be subject to dollar limits, deductibles or co-insurance provisions that are less favorable than other coverage included in the policy;
- requires the policies to cover one breast cancer screening mammography for a woman between 35 and 40 years old, one mammography every two years for a woman between 40 and 50 years old (unless the woman is high-risk, then she should be allowed one mammography every year), and one mammography every year for a woman older than 50.
- This act applies to all state insurance contracts that are issued or renewed after June 30, 1992.

SEA 412

- Authors: Pease, Soards
- House sponsor: Kruzan
- Allows a petitioner in a civil commitment case to choose whether or not to hire counsel (applies to both individual and corporate petitioners);
- requires non-attorneys who represent corporations at civil commitment hearings to present to the court written documentation from a director, officer, principal or manager of the corporation proving that the individual is duly authorized to represent the interest of the corporation.
- Effective July 1, 1992.

1992 legislative morgue

It is often true that what does not become law is more significant than what does become law. Nearly 70% of the bills introduced during the 1992 session died at some point during the process. Many of those bills were tracked by the ISMA legislative staff, and some of the most significant ones are summarized below in the 1992 legislative morgue.

House Bill 1001

Author: Hayes

Digest: Would have allowed patients to indicate in a living will that they would like to have nutrition and hydration withheld in the event that they become terminally ill or in a persistent vegetative state.

House Bill 1023

Author: Brown

Digest: Would have provided for a universal health care system in Indiana, administered by state government. Prohibited private health insurance policies in favor of a single payor.

House Bill 1037

Authors: Kruzan, Kruse

Digest: Would have prohibited a person from consuming an alcoholic beverage while operating a motor vehicle.

House Bill 1091

Authors: Villalpando, Cottey

Digest: Sought to provide that certain relatives of a decedent could recover certain damages in a wrongful death action. Provided that these relatives could cover damages for grief, loss of society, companionship, guidance or love and affection.

House Bill 1170

Author: Villalpando

Digest: Would have prohibited a person from consuming an alcoholic beverage while operating a motor vehicle.

House Bill 1220

Author: Goodall

Digest: Sought to allow the state Workers Compensation Board (comprised 100% of attorneys) to implement a fee schedule for physician reimbursement for services performed under workers compensation.

House Bill 1222

Author: Phillips

Digest: Would have prohibited physicians from charging for the first hour of consultation with a patient or a patient's attorney when the patient's health care was at issue in a legal proceeding.

House Bill 1366

Authors: Day, Donaldson

Digest: Would have increased the tax on cigarettes by \$.45 per pack (the tax is currently \$.155). Revenue would have been distributed as follows: 1) 10% to the cigarette tax fund; 2) 5% to mental health centers; 3) 20% to the state general fund; 4) 15% to the pension relief fund; 5) 25% to CHOICE; 6) 10% to the local health maintenance fund; 7) 10% to the preventative health care account; and 8) 5% to a first steps account.

House Bill 1395

Author: Klinker

Digest: Sought to provide certification and title protection for the title "professional counselors."

House Bill 1399

Author: Grubb

Digest: Would have allowed physicians to test patients for HIV with general health care consent, negating the need to obtain special documented consent.

House Bill 1410

Author: Kinser

Digest: Addressed several aspects of physician discipline. Required the attorney general to employ a physician to review complaints and set investigative priorities.

Senate Bill 27

Authors: Wyss, Alexa, Zakas, Maidenberg

Digest: Would have prohibited a person from consuming an alcoholic beverage while operating a motor vehicle. Prohibited a person in a passenger car or truck from having an open alcoholic beverage container in the vehicle.

Senate Bill 30

Authors: Alexa, Wyss

Digest: Would have made it unlawful for a person less than 21 years old to operate a motor vehicle with a blood alcohol level of 0.01% to 0.10%. Established the punishment of a maximum fine of \$500 and a maximum driver's license suspension for up to one year.

Senate Bill 155

Authors: Wyss, Maidenberg

Digest: Sought to reduce the percentage of alcohol by weight in a person's blood from 0.10% to 0.08% that is necessary to constitute prima facie evidence of intoxication in a prosecution for operating a motor vehicle or watercraft while intoxicated.

Senate Bill 170

Author: Leising

Digest: Would have made it a Class B felony for a person to intentionally assist or provide the means of assisting another human being to commit suicide.

Senate Bill 179

Authors: Blankenbaker, Leising

Digest: Would have required that all children, teachers and other school employees be immunized against certain diseases as a condition of continued attendance at the school. Established similar

immunization requirements for students and employees at postsecondary level educational institutions.

Senate Bill 198

Author: Corcoran

Digest: Would have provided for the licensure of athletic trainers.

Senate Bill 200

Author: Corcoran

Digest: Would have specified that a local unit of government is not permitted to regulate firearms and ammunition except to the extent of prohibiting the discharge of a firearm in an area where the discharge would endanger people or property.

Senate Bill 253

Author: Meeks

Digest: Would have provided for the certification of hypnotists.

Senate Bill 277

Author: Alexa

Digest: Would have provided for licensure of acupuncturists.

Senate Bill 304

Author: Miller

Digest: Sought to require the sunset division of the legislative services agency to prepare a preliminary written evaluation of a bill that concerns the licensure, certification, registration, regulation, scope of practice or third-party payment of a health professional or an allied health practitioner. Required the evaluation to be submitted to the executive committee of the department of health for comment. Required the chairman of a legislative committee to consider the availability of such an evaluation when scheduling a bill for a hearing.

Senate Bill 355

Author: Miller

Digest: Would have provided that a comprehensive insurance policy that includes mental health coverage may not: provide coverage for mental disorders that is different from coverage for other illnesses, conditions or disorders that are covered by the policy or discriminate in the reimbursement of the cost of health care services on the basis of diagnosis indicating a mental disorder.

Senate Bill 403

Authors: Worman, Craycraft

Digest: Would have provided that a person who assists, aids or abets another human being in com-

mitting suicide commits a Class C felony.

Senate Bill 418

Author: Server

Digest: Would have required an individual or entity who conducts routine mass health screens to register with the state department of health. Mandated that the department adopt rules for standards for routine mass health screens including appropriate patient follow-up.

Senate Bill 421

Authors: Riegsecker, Smith K.

Digest: Would have provided that if certain conditions are met, an insurance policy that provides coverage for drugs could not exclude coverage of a covered drug for a particular indication on the grounds that the drug had not been approved by the U.S. Food and Drug Administration for the particular indication. □

Index

Those bills marked with an asterisk (*) were not successful during the 1992 session of the Indiana General Assembly. Summaries of these bills can be found in the legislative morgue.

Acupuncturists LicensureSB 277*

AIDS:

- Skilled nursing reimbursement rate (Medicaid)SEA 106
- Testing without informed consentHB 1399*

Alcohol:

- AnticonsumptionHB 1037*, HB 1170*, SB 27*
- AnticontainerHB 1037*
- MinorsSB 30*
- Reduction of legal blood alcohol levelSB 155*

Americans With Disabilities ActSEA 255

Assisted suicidesSB 170*, SB 403*

Athletic trainers' licensureSB 198*

Breast cancer:

- Education RequirementsSEA 129
- Mandated Coverage in State Health PlansSEA 391

Children:

- Child abuse (Commission on)HEA 1035
- Children's Mental Health BureauSEA 176
- ImmunizationsSB 179*
- Infants and Toddlers With Disabilities ProgramHEA 1370, HEA 1396
- Information Management CommitteeSEA 176
- Juvenile Law Study CommitteeSEA 176
- "Wrap-around" Pilot ProgramSEA 176

Cigarette tax increaseHB 1366*, SB 425*

Controlled substance taxHEA 1129

DefibrillatorsHEA 1030

Disproportionate share hospitalsHEA 1095

Drug utilization reviewHEA 1337

Education (cancer curriculum required)SEA 129

Emergency medical services
(Defibrillators)HEA 1030

Endangered adultsSEA 37

FirearmsSB 200*

Hospitals:

- County hospital board appointmentsHEA 1004
- Disproportionate shareHEA 1095
- RecordsHEA 1004

Hypnotists' certificationSB 253*

Insurance:

- Small employer group health planHEA 1146
- Group health cancellation & renewalHEA 1180
- Medicare supplemental policiesSEA 91
- Breast cancer screening mammogramsSEA 391

Lake County innkeeper's taxHEA 1095

Living willsHB 1001*

MammogramsSEA 391

Mass health screeningsSB 418*

Medicaid (Recipients'
Administrative Review)SEA 177

Medicare - supplemental policiesSEA 91

Mental health:

- Children's Mental Health BureauSEA 176
- Community residential facilitiesSEA 177
- Court ordered medication.....SB 435*
- Developmental disabilitiesSEA 176
- Division of Mental HealthSEA 177
- Insurance coverageSB 355*
- Petitioner's right to waive
legal representationSEA 412

Nursing homes:

- Certificate of NeedSEA 106
- Pre-admission screening process.....SEA 176

Off-label drug prescriptionsSB 421*

Organ donationHEA 1006

Physician consultationsHB 1222*

Physician disciplineHB 1410*

Professional counselorsHB 1395*

Sunrise (Allied Health
Professionals Licensure)SB 304*

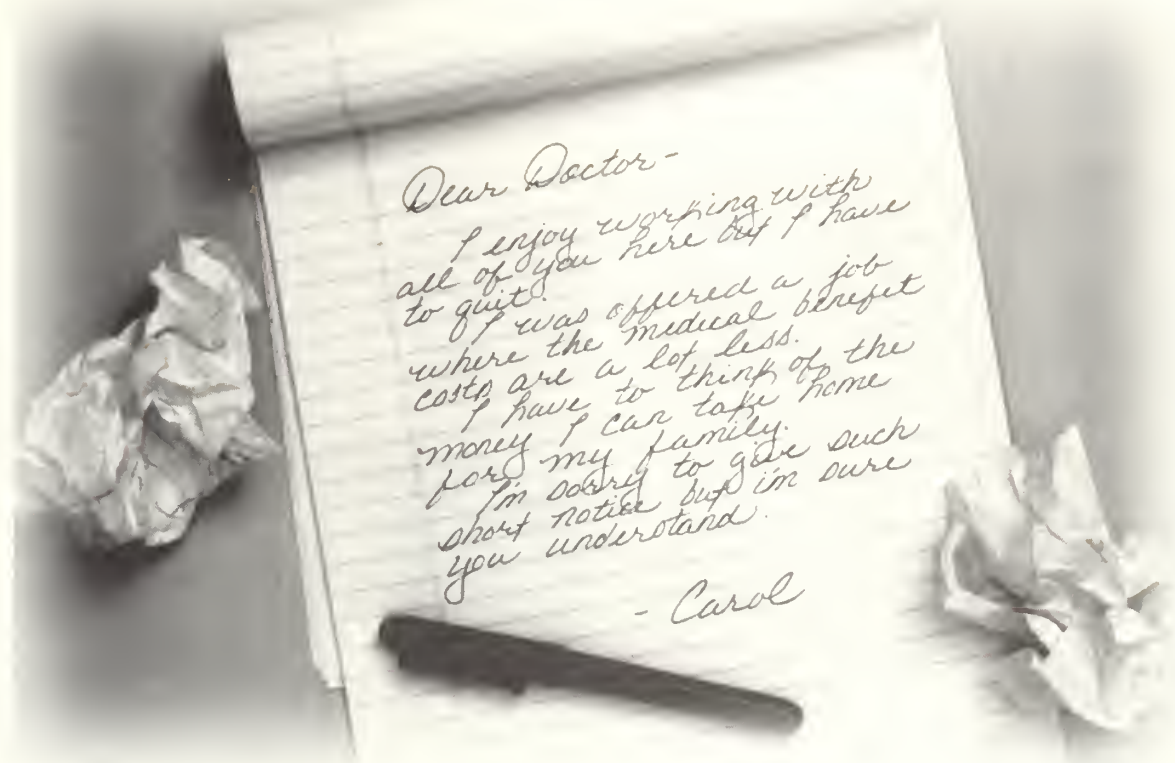
Universal health care systemHB 1023*

Utilization reviewHEA 1182

Workers compensation:

- Physicians' statementSEA 239
- Employee choice of physicianHB 1220*

Wrongful deathHB 1091*



Save on Group Health Insurance with our new **Professional Courtesy** plan.

Exclusive from Gregory & Appel Insurance.

*Professional Courtesy** is a new group health plan with 20% to 50% savings for physicians... additional 9% to 15% less with PPO discounts. Can reduce a physician's taxes. Dual deductible option: one for staff and a higher deductible for physicians.

Professional Courtesy is serviced by expert, salaried (not commissioned) employees of Gregory & Appel Insurance who provide a complete range of risk management products.

Phone Jan Messick or Greg Wright, CFP
(317) 634-7491 or 1-800-968-7491

**Gregory
& Appel
Insurance**

A Tradition of Quality - Since 1884

333 N. Pennsylvania Street
Indianapolis, IN 46204

*a fully-insured product underwritten by Benicorp Insurance Company of Indiana. **BENICORP**

New faces in statehouse —may change ISMA strategy—

Mike Abrams
ISMA Director of Marketing/
Legislation

As unbelievable as it may sound, the Indiana General Assembly can be an incredibly predictable body. Each year, lobbyists hastily examine the introduced bills and, after going through hundreds of bills, realize that many are not new ideas at all – they have been introduced for years. A quick look at previous years' action on the bills can be a fairly good indicator of the bill's prognosis for the current session.

The 1993 session will likely challenge old records for new ideas, and the prognosis of the introduced bills will be impossible to assess. In short, everything old is new again. Expect the unexpected. Prepare for the worst and hope for the best.

Why this expected sudden change in collective legislative behavior? A total of at least 260 years in legislative experience is walking out the statehouse door, some voluntarily and some because the voters in Indiana's May 5 primary election kicked the legislator out the statehouse door. While some would say that this is a refreshing change – career politicians might not be good for the general citizenry – such a turnover in the General Assembly will make it difficult to plan legislative

strategy. Throw out the old strategy books, because what worked yesterday is not guaranteed to work tomorrow.

The implications of this change in the General Assembly are virtually unpredictable. But one thing is known: Many legislators who are not returning had a profound impact on health care policy in Indiana during the time they served. Whether this is a change for the better or not largely depends upon who is elected to fill these vacancies.

A look at those who are not returning will provide a good understanding of the potential impact of this change.

ment and less on doing favors for constituents and much less on partisan bickering. He remembers the first Indiana budget that surpassed \$1 billion in 1961, and he recalls thinking at the time "My God, we are big spenders." The budget that was adopted in 1991 spent 22 billion taxpayer dollars. He recalls the fiery debate that took place in 1975 over medical malpractice, a law that eventually became a national model. Donaldson's position as judiciary chairman, a job he was assigned in 1971, allowed him to become intimately involved in several bills that sought changes in Indiana's system of compensating patients

for malpractice.

One of Donaldson's proudest accomplishments during his 34 years of service is his authorship of the current law re-

***In short, everything old is new again.
Expect the unexpected. Prepare for the
worst and hope for the best.***

House members



Donaldson

Rep. John Donaldson (R-Lebanon) first ran for the Indiana House of Representatives when Dwight Eisenhower was president, Harold

Handley was preparing to move in to the governor's office, and Bill Jenner and Homer Capehart represented Indiana in the U.S. Senate.

Donaldson remembers his first years in the legislature as years where legislators concentrated more on policy develop-

quiring public places to designate "no smoking" areas.

Donaldson chose not to run for re-election. His likely replacement is Kathy Willing, who won a five-candidate Republican primary battle. Although she must be elected in November, she should easily win, as the district is strongly Republican.

Rep. Kent Adams (R-Bremen) was elected to the House of Representatives in 1988. While he was in the House, he served on two committees that have enormous impact on health legislation: public health and ways and means. His departure leaves an opening on those two committees, and the person who fills those

vacancies will pass judgment on several bills of importance to Indiana physicians. Adams vacated his House seat to run for the state Senate. In November he will face incumbent Sen. Betty Lawson (D-South Bend), who serves on the Senate Health and Human Services Committee.

Rep. Anita Bowser (D-Michigan City), a state representative since 1980, also left the House to run for the Senate. She was appointed to complete the term of Sen. Dennis Neary, who resigned. Bowser served as deputy speaker pro tem of the House and was an enthusiastic supporter of abortion rights legislation in the Indiana House.

Rep. Larry Buell (R-Indianapolis) leaves the House after serving as a state representative since 1980. As executive director of the Marion County Health and Hospital Corporation, Buell has a background in health policy that has allowed him to be a respected voice in legislation affecting health care. His membership on the House Aging Committee and the House Ways and Means Committee gave him opportunities to be a major voice in health care issues. Buell leaves the House after losing a Marion County Republican Party slating convention. When he lost the slating nomination to Rep. George Schmid, Buell chose not to run in the May 5 primary election.

Rep. Richard Dellinger (R-Noblesville) leaves a House leadership position to seek a seat in the Indiana Senate. When Republicans controlled the House, Dellinger was the "Number Two Leader" as house majority floor leader. He has served as assistant minority leader since the Democratic Party won the majority. His

membership on the House Judiciary Committee, coupled with his leadership position, has allowed him to develop a record on health policy. In November he will face incumbent state Sen. Tony Maidenbourg.



Goodall

Rep. Goodall became assistant majority floor leader. He also serves as chairman of the Black Legislative Caucus, and his legislative abilities have been widely respected. He steered legislation through the House of Representatives that would have allowed the worker's compensation board to implement fee schedules for physicians, but the bill later died in the Senate. He also introduced legislation that would have established a system of implementing Indiana Medicaid similar to the system that was passed in Oregon, where health services are ranked, and persons at or below 100% of the federal poverty level are covered for those services funded by the legislature.

Goodall will almost certainly be replaced by Billy Linville, who won the Democrat primary election. Linville was an assistant to Congressman Phil Sharp.



Hric

Rep. Hurley Goodall (D-Muncie) retires from the House after 14 years of service. When Democrats gained control of the House in 1990,

Rep. Paul Hric (D-Hammond), had he won, would have replaced Rep.

John Donaldson as the most senior member of the House of Representatives. Hric has been in the House for 26 years and most recently served as chairman of the House Government Affairs Committee. This committee considered most of the legislation that established certification for health professions, so his position on these issues was important to ISMA's legislative efforts. Because this is a strong Democrat district, Hric will almost certainly be replaced in the House by Ron Tabaczynski, who beat him in the primary. Tabaczynski previously served on the House Democrat Caucus staff.

Rep. Don Nelson (R-Indianapolis), a former Public Health Committee chairman, leaves the House after being defeated by Rep. John Keeler (R-Indianapolis). This show-down by two Republican incumbents came about when the redistricting maps approved during the 1991 legislative session put Nelson and Keeler in the same district. Nelson's position on the Public Health Committee gave him credibility on health issues. He was an outspoken opponent of legislation that would allow persons to specify in living wills that they would like nutrition and hydration withheld in the event they are in a persistent vegetative state or in a terminally ill condition. "Pro-choice" abortion supporters supported Keeler's candidacy, as Nelson was enthusiastically "pro-life." A retired industrial psychologist from Eli Lilly, Nelson introduced legislation initiated by the ISMA that would enable physicians to test patients for HIV with general health care consent, rather than the specific documented consent that current law requires.

Other House members who are not returning are: Rep. Richard Bray (R-Martinsville); Rep. Keith Bulen (R-Indianapolis); Rep. David Cheatham (D-North Vernon); Rep. Brad Fox (R-Rome City); Rep. Steve Gabet (R-Grabill); Rep. Dave Hoover (R-Ridgeville); Rep. Dave Jones (R-Camby); Rep. Raymond Musselman (R-Peru); Rep. Frank Newkirk (R-Salem); Rep. John Ruckleshaus (R-Indianapolis) and Rep. Robert Sabatini (D-Logansport).

Senate members

Sen. Virginia Blankenbaker's (R-Indianapolis) departure from the state Senate leaves an important vacancy in the Senate leadership: the chairmanship of the Senate Health and Human Services Committee. Blankenbaker has served in the Senate for 12 years, representing a strong Republican Indianapolis district. Teresa Lubbers is the Republican nominee, so she should easily win the November contest.

Sen. Joe Corcoran (R-Seymour) retires from the state Senate after 12 years of service. He has served as chairman of the Senate Public Policy Committee, where he was instrumental in helping the ISMA defeat legislation aimed at credentialing and defining scopes of practice for ancillary health providers. Corcoran's replacement as chairman of this committee will be important to ISMA's legislative efforts.

Sen. Louis Mahern (D-Indianapolis) leaves the Senate after 16 years. His retirement comes after losing the Indianapolis mayoral election to Steve Goldsmith. Mahern closes out his public ser-

vice with an appointment to the Interim Study Committee on Insurance Issues, a committee reviewing the Indiana Compensation Act for Patients (INCAP) during the summer months. Replacing Mahern in the state Senate will almost certainly be Glenn Howard (D-Indianapolis). Howard, a member of the Marion County Council, won the Democratic primary and is heavily favored in this Democratic district.

Sen. Dennis Neary's (D-Michigan City) retirement from the Senate after 16 years of service came as a surprise to many people. As minority leader in a Senate that was only narrowly controlled by Republicans (26-24),

Indiana Trial Lawyers Association to expand Indiana's wrongful death statute. Several Republican party leaders are rumored to have approached the retiring senator to run for attorney general, a request that Pease is said to have turned down. Pease's replacement as judiciary chairman is important in efforts to keep INCAP intact.

Sen. Thurman Ferree (D-Hammond) also is leaving the Senate.

That so many veteran legislators are not returning presents some formidable challenges to organizations with legislative interests.

The policies on which legislators must pass judgment are often

Therefore, an important challenge for the ISMA is to educate legislators, especially the new ones, about INCAP, Medicaid policy and other important issues.

Neary wielded significant power. He is replaced as Senate minority leader by Bob Hellmann (D-Terre Haute), an attorney who has served on the Judiciary Committee. Neary's Senate seat was filled by Anita Bowser (D-Michigan City), who served 12 years in the House of Representatives.

Sen. Ed Pease (R-Brazil) chose to leave the Senate after 12 years. His position as chairman of the Senate Judiciary Committee put him in a position of power over all tort bills considered by the General Assembly. As a supporter of INCAP, Pease was instrumental in preserving the act. He also disrupted efforts by the

difficult to digest. While you do not want legislators passing judgment on major public policy initiatives without knowing the full impact of legislation, the "learning curve" associated with many public health issues is considerable. Therefore, an important challenge for the ISMA is to educate legislators, especially the new ones, about INCAP, Medicaid policy and other important issues.

Realizing that no person can become an expert on hundreds of important issues, legislators like to think that they are reflecting their constituents' wishes when they vote. For that reason, it is critical that physicians and their families

call and write their state representatives and senators often to ask for votes in favor of or in opposition to bills of interest to health care. If these legislators hear only from lawyers seeking to dismantle INCAP, ancillary providers seeking to expand their scopes of practice, and other constituents with views in opposition to physicians' views, legislators will be compelled to vote against physicians.

And the legislature's "new face" could not come at a more challenging time for Indiana physicians. Several issues that will be debated in 1993 are of critical importance to physicians.

INCAP has not been a major legislative issue in Indiana since 1989, when House Bill 1777 increased the cap on damages from \$500,000 to \$750,000. However,

the appointment of INCAP as a topic of legislative study guarantees that it will be an issue during 1993. In response to a request by Rep. Bill Crawford (D-Indianapolis), INCAP will be studied by the Interim Study Committee on Insurance Issues. This committee, chaired by Rep. Craig Fry (D-Mishawaka), will review the process followed in cases of medical malpractice claims and will recommend changes to the 1993 legislature. Other members of the committee: Rep. Ed Goble (D-Batesville), Rep. Earl Howard (D-Kokomo), Rep. Jerry Bales (R-Bloomington), Rep. Brian Bosma (R-Indianapolis), Rep. Phyllis Pond (R-New Haven), Sen. Joe Harrison, co-chairman, (R-Attica), Sen. Tom Weatherwax (R-Logansport), Sen. Richard Worman (R-Leo), Sen. Bill Alexa

(D-Valparaiso), Sen. Louis Mahern (D-Indianapolis) and Sen. Joe O'Day (D-Evansville).

Health care reform and cost containment also will likely be an issue during the 1993 legislative session. With health insurance consuming an increasing share of private and public dollars, legislators are under pressure to take measures aimed at curbing the rate of increase of health insurance. Legislators from several other states have answered this challenge in ways adversarial to physicians. It will be important for Indiana physicians to educate the legislators, perhaps especially the new legislators, about the full impact of some of the cost containment ideas that are introduced. ▢

Millions Victimized by Family Members Every Year!

Are you concerned about the effects of family violence and victimization within your community?

Become an advocate within your community for the prevention of family violence.

Violence among family members has reached staggering proportions. Every year more than 2 million cases of child abuse and neglect are reported, between 2 and 4 million women are battered by their spouses, and between 700,000 and 1.1 million of the elderly population are abused.

The American Medical Association has formed a *National Coalition of Physicians Against Family Violence*. Through the *Coalition* the American Medical Association hopes to involve you in activities that address issues of child abuse, sexual assault, domestic violence and elder abuse because you have the unique ability to identify the symptoms, first-hand. By joining the *National Coalition* you will be showing your concern about the effects of family violence and victimization, and will become a committed advocate within your community for the prevention of family violence.

Through the *Coalition* you will:

- be informed about local contacts and referrals
- become aware of local and regional resources
- be provided with information regarding model educational programs
- become aware of treatment guidelines and protocols.
- have access to newsletters, public education materials and other publications
- receive an official membership card and frameable poster alerting your patients of your interest in and concern for this problem.

The only **cost** to you is **your commitment** to help curb this problem. Simply complete the membership application form below and mail to the Department of Mental Health, American Medical Association, 515 N. State Street, Chicago, IL 60610.

Yes, include my name in the *Coalition's* membership

Name

Address

City/State/Zip Telephone #

Specialty

Auxiliary Member ☐ Yes ☐ No Other

Area of interest within Family Violence: ☐ Child Abuse ☐ Sexual Assault ☐ Domestic Violence

☐ Elder Abuse ☐ Other

American Medical Association

Physicians dedicated to the health of America



RVU x GAF x CF = ?

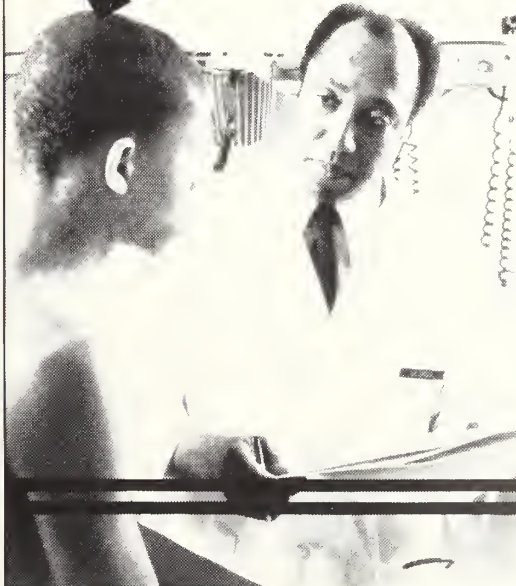
AMS can now provide solutions to your new MEDICARE - RBRVU problems

- * Quick, computerized, custom-designed coding conversions
- * Pre-printed, custom-coded SUPERBILLS for your office use
- * Identification of the new CPT/EM/EV codes for your practice
- * Calculation of your modifiers, GPCIs, RVU/AHPB based fees
- * Electronic processing of claims to our ALL-PAYOR network

AMERICAN MEDICAL SERVICES
1099 N. Meridian Street * Suite 630
Indianapolis, IN 46204

For more information,
please call
(317) 630-3697

**AIM
HIGH**



CREATE A MEDICAL BREAKTHROUGH.

Become an Air Force physician and find the career breakthrough you've been looking for.

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay per year

Today's Air Force provides medical breakthroughs. Find out how to qualify as a physician or physician specialist. Call

**USAF HEALTH PROFESSIONS
COLLECT**
(317) 848-5830



Rabies in Indiana: It's still a threat

Charles L. Sinclair, DVM, MSPH
Indianapolis

Rabies has been the subject of legends for centuries. It is one of our most misunderstood public health problems, and it's still with us. Before the late 1950s, the dog was the principal source of human exposure. Fortunately, we now have effective canine and feline vaccines and laws mandating the immunization of dogs. We also have more efficient community animal control services to reduce stray animal populations.⁴

Today, most cases of rabies diagnosed in the Indiana State Department of Health (ISDH) laboratory are in wildlife: bats, skunks and foxes. While we have made great strides in protecting the public from this dread disease, we cannot afford to become complacent. Rabies remains a threat. Raccoon rabies, once a problem in the South, has become a major problem in the Middle Atlantic States and is spreading through New England. The illegal interstate transportation of raccoons to Indiana could introduce the raccoon-adapted strain at any time.

This article reviews the basic rationale regarding the need for rabies prophylaxis, the biologicals available for treatment and the current status of the disease in Indiana animal populations.

First, a cursory review of the biologicals used in rabies prophylaxis is in order.

People requiring postexposure prophylaxis following a potential rabies exposure receive human rabies immune globulin (HRIG) (Hyperab or Imogam at 20 IU/kg) and a series of five 1 mL intramuscular injections of human diploid cell vaccine (HDCV) (Imovax) given on days 0, 3, 7, 14 and 28. Both products should be used. They are usually available in emergency departments and pharmacies of larger hospitals. They also can be ordered and shipped directly from the manufacturer, Connaught-Merieux, by calling 1-800-VACCINE. The series generally costs between \$1,000 -1,500, depending

should not be used in postexposure treatment. The intramuscular product should not be given ID.¹ Remember that despite pre-exposure immunization, additional immunizations are recommended in the event of a rabies exposure. If an immunized patient sustains a potential rabies exposure, a series of two IM boosters with HDCV should be given.

Consult the 1992 *Physicians' Desk Reference* for details on indications, dosage schedules and risks associated with use of these products.

Immediate and thorough wound cleansing is of equal importance in the prevention of rabies infection. Patients should be instructed to thoroughly but gently wash the wound with warm soap and water. Once the

Raccoon rabies, once a problem in the South, has become a major problem in the Middle Atlantic States and is spreading through New England.

patient's weight, source of the vaccine and fees for administration. Most insurance policies will cover the costs of postexposure prophylaxis. The Rabies Postexposure Prophylaxis Schedule 1991 table reflects the current recommendations of the Centers for Disease Control on rabies prophylaxis in humans.²

People requiring pre-exposure prophylaxis due to occupational risk of acquiring the disease receive human diploid cell vaccine (HDCV) (Imovax for intramuscular use, or Imovax for intradermal use). A series of three injections is given over a three- to four-week period. The intradermal product

patient arrives for treatment, lavage and debridement should be performed as necessary.³

The three principal factors we must assess in determining the need for postexposure prophylaxis are:

- 1) Risk of rabies in the biting species – This includes looking at the history of rabies in the local animal population and the biting species. If the biting animal is not available for testing, the physician must assess the probability that the animal was rabid based on historical data and the circumstances surrounding the incident. A brief overview of the types of biting animals in Indiana is given

below.

Bats – All bats in Indiana are insectivorous. They seldom come in contact with man. Hematophagous “vampire bats” are a problem in Central and South America. The prevalence of rabies in bats is high. About 5% of submissions to our laboratory are positive. Thus, we recommend that people bitten or scratched by bats unavailable for testing receive postexposure prophylaxis. If the bat is captured, it should be administered euthanasia and submitted intact to the ISDH laboratory for rabies testing and speciation.

Foxes, skunks and raccoons – These carnivores are a serious problem. While we have had no recent cases of rabies in raccoons,

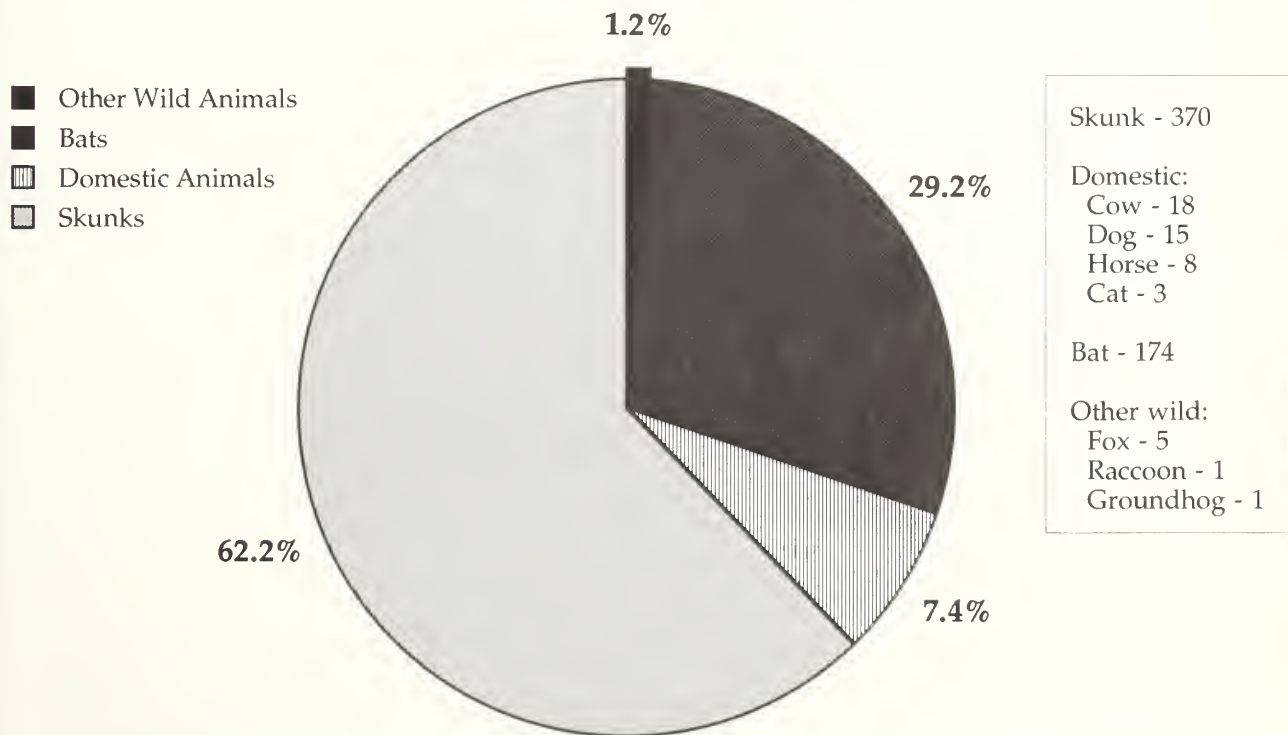
the threat of raccoon rabies introduced from epidemic sites on the East Coast and in the Southwest is ever present. All three of these species are vulnerable to canine distemper virus, a paramyxovirus that can cause neurological and behavioral signs clinically indistinguishable from rabies. People exposed to these animals unavailable for testing should receive rabies prophylaxis.

Farm animals – These animals are unlikely to be rabid. However, “spillover” from wildlife reservoirs is possible. The principal early symptoms exhibited by rabid horses and cattle are ataxia and “choke.” The caretaker will often open the mouth in an attempt to find a foreign object ob-

structing the airway. In so doing, exposure to virus-laden saliva is likely. These animals progress within a matter of days to recumbency, coma and death. Most veterinarians are aware of the possibility of rabies in such cases and will have the head tested. In general, all people exposed to the saliva of rabid livestock should undergo postexposure prophylaxis. We assume that livestock workers have small cuts, abrasions or cracks in the skin that might allow the virus to enter the body.

Dogs and cats – In urban areas, dogs and cats are unlikely to be rabid. However, “spillover” from wildlife can occur occasionally. Contrary to popular opinion, most

Rabies in Indiana, 1974-1991



bites are not inflicted by stray animals. Most are made by a pet known to the victim. Indiana law requires that dogs and cats that have bitten someone to be confined and observed for signs of rabies for 10 days. Vaccinated dogs and cats usually are placed under a more relaxed quarantine regimen. The vaccine used in dogs and cats has been shown to be highly protective against rabies

virus challenge.

Rodents and rabbits – Historical and ecological data demonstrate that these animals seldom, if ever, transmit rabies. The exceptions are muskrats and groundhogs. These large rodents can survive an attack by a rabid animal and may pass the virus in a bite. The opossum, a marsupial, is rarely rabid. However, people exposed to an opossum that showed evi-

dence of neurologic impairment or inflicted an unprovoked bite are candidates for prophylaxis.

2) Circumstances surrounding the bite incident – Bite victims should be questioned about the behavior of the animal at the time of the bite. Was it unusually aggressive? Did it appear to be neurologically impaired? Was the attack unprovoked? Provocation does not necessarily mean the

Table

Rabies postexposure prophylaxis schedule, United States, 1991²

<u>Vaccination status</u>	<u>Treatment</u>	<u>Regimen*</u>
Not previously vaccinated	Local wound cleansing	All postexposure treatment should begin with immediate thorough cleansing of all wounds with soap and water.
	HRIG	20 IU/kg body weight. If anatomically feasible, up to one-half the dose should be infiltrated around the wound(s) and the rest should be administered IM in the gluteal area. HRIG should not be administered in the same syringe or into the same anatomical site as vaccine. Because HRIG may partially suppress active production of antibody, no more than the recommended dose should be given.
	Vaccine	HDCV or RVA, 1.0 mL, IM (deltoid area [†]), one each on days 0, 3, 7, 14, 28.
Previously vaccinated [§]	Local wound cleansing	All postexposure treatment should begin with immediate thorough cleansing of all wounds with soap and water.
	HRIG	HRIG should not be administered.
	Vaccine	HDCV or RVA, 1.0 mL, IM (deltoid area [†]), one each on days 0 and 3.

* = These regimens are applicable for all age groups, including children.

† = The deltoid area is the only acceptable site of vaccination for adults and older children. For younger children, the outer aspect of the thigh may be used. Vaccine should never be administered in the gluteal area.

§ = Any person with a history of pre-exposure vaccination with HDCV or RVA; prior postexposure prophylaxis with HDCV or RVA; or previous vaccination with any other type of rabies vaccine and a documented history of antibody response to the prior vaccination.

victim was abusing or teasing the animal. Entering a dog's territory or riding a bicycle near it may be sufficient to cause an attack in many healthy dogs.

3) Risk of transmission to the patient – This includes evaluation of the wound and the likelihood that infected saliva may have been introduced parenterally. Scratches as well as bites are dangerous because many mammals, especially felines, lick their paws frequently. Skin contact with virus-laden saliva may constitute an exposure as well. A rabies exposure can be defined "as any penetration of skin by the teeth of potentially rabid animal or contamination of scratches, abrasions, open wounds or mucous membranes with the saliva or potentially infectious material (such as brain tissue) of a potentially rabid animal."² The virus is vulnerable to desiccation and heat. It does not survive long outside the body.

We also must consider the credibility of the report the patient or parent gives and the ability of the patient to accurately identify the biting species. If the biting animal has been captured for observation, make sure the patient has identified and captured the right animal. It is also good to explain the relatively simple course of prophylaxis used today. Many people, especially children, may be reluctant to talk about the bite because they fear getting the now obsolete "25 shots in the stomach."

Occupational health issues

People in certain high-risk occupations, such as veterinarians, zoo keepers, animal control officers and others with frequent exposure to mammals, should take the prescribed series of three immunizations. Most animal workers in Indiana have infrequent exposure² to the disease.

After completing the initial series, booster doses and postimmunization titers are not indicated. Vaccine studies conducted throughout the world have shown an extremely high level of protective efficacy. However, physicians wishing to obtain follow-up titers can contact the ISDH for information on the laboratory that performs this test.

We occasionally receive calls from cave explorers concerned about acquiring rabies by aerosol. This has been documented in one large bat cave – Frio Cave in Texas. It has not been shown to occur at other sites in the United States; however, people exploring caves with large bat populations should wear a dust-mist type of mask to provide some protection from airborne *Histoplasma capsulatum*, which may proliferate in bat guano. It is unknown whether this also protects against rabies.

People traveling to developing countries, especially those staying in rural areas and working in agricultural occupations, are candidates for immunization. In Asia, thousands of people die

from rabies each year. Incidentally, people receiving chloroquine for malaria prophylaxis during administration of the rabies series may not achieve protective levels of immunity.

When in doubt, consult your local health department or the ISDH. For more information on rabies-related services at the ISDH, call the rabies laboratory, (317) 633-0248, or the rabies/animal bite consultation service, (317) 633-0112. To arrange professional educational programs, call (317) 633-0112. Physicians who need information after hours may call (317) 633-0144. □

Correspondence: Charles L. Sinclair, D.V.M., M.S.P.H., Indiana State Department of Health, 1330 W. Michigan St. Indianapolis, IN 46206.

The author is a veterinary epidemiologist at the Indiana State Department of Health in Indianapolis.

References

1. Bernard KW, Mallonee J, Wright JC, et al: Pre-exposure immunization with intradermal human diploid cell vaccine. *JAMA*, 257:1059-1063, 1987.
2. Centers for Disease Control, Rabies Prevention – United States – 1991: Recommendations of the Immunization Practices Advisory Committee. *MMWR*, April 22, 1991.
3. Fishbein DB, Sawyer LA, Winkler WG: *Rabies Concepts for Medical Professionals*, 2nd ed., Miami, Fla: Merieux Institute; 1986.
4. National Association of State Public Health Veterinarians. *Compendium of Animal Rabies Control* - 1992.

Working vacations in the Third World for physicians and dentists

Robert D. Robinson, M.D.
Indianapolis

Opportunities exist throughout the world for health care workers to fill short-term needs and in so doing encounter cultural experiences rarely available to others. While receiving the satisfaction of providing care to patients who might otherwise have none, volunteers can give themselves and their families a memorable travel experience – one that is truly interactive with local people.

Organizations sponsoring short-term medical work in Third World countries do so because they either need substitutes for regular full-time personnel who have left for vacation or illness or because their

mission is to provide such opportunities for physicians. These organizations can be religiously based or totally secular.

The lengths of service may vary from several days to months. The work may be purely service, teaching or a combination. The location may be primitive environments, large cities or a ship. All of the volunteer working vacations provide physicians with an opportunity to immerse themselves in a different culture and have person-to-person contact unimpeded by the usual wall that exists between tourists and natives. While the organizations supporting such visits usually cannot afford travel and salary expenses, they often can provide

room and board.

Potential volunteers may hesitate because of the following concerns:

1) I don't know anything about "tropical medicine."

Surprisingly, the great burden of illness is the same anywhere in the world (i.e., skin infections, peptic ulcer, trauma, cataract, dental abscess, emotional upset, goiter, hernia, pneumonia, diarrhea and other illnesses we see everyday). Colleagues on site can teach the local protocols for local illnesses.

2) What would my family do? Various useful and stimulating activities exist for family

treated locally, evacuation insurance is available.

5) Would I have time for anything but work? Most Third World work schedules permit adequate time for vacationing locally. In addition, you can arrange a nice itinerary coming and going.

Some good reasons to consider a working vacation:

1) Involvement – both with medical colleagues and the indigenous people. Some of these friendships are for life.

2) Satisfaction – from feeling even a little bit needed and recognizing that you can function with limited technology.

3) Savings – from living in a style that is much less expensive than it would be for a tourist. Your on-site col-

leagues will guide you to the best transportation, eating and shopping bargains.

4) Deduction on your income taxes. If you can convince Uncle Sam that you went for work rather than pleasure and were under the auspices of a 501 c3 organization, your legitimate expense may be deductible. The Internal Revenue Service does not have to know how much fun you had.

Here are some do's and don't's for volunteers to consider:

Do

1) Try to learn a little of the language, even if only "hello," "goodbye" and "thank you."

2) Participate as much as

All of the volunteer working vacations provide physicians with an opportunity to immerse themselves in a different culture ...

members. For example, the family can help to care for the sick or teach English. Babysitters are very inexpensive in this type of society. Family members may reap the most benefits from a stay abroad.

3) Would I be of any real help? This is a relative question. While the world would go on if you stayed home, you are probably meeting needs that otherwise would be unmet. If you don't burden the organization with your own problems, anything you do is a plus.

4) What if I get sick? If you take your shots, avoid unboiled water and use your head, you probably won't get sick. If you do become ill and you can't be

possible in local activities, and try the food (if cooked).

3) Play by the local rules medically. If impetigo is treated with gentian violet and soap, it probably works. Try it! Fancy and expensive medicines and practices you bring with you may create disappointment when you leave.

4) Show respect for your foreign medical counterparts. They probably have dealt with obstacles you can only imagine.

Don't

1) Don't make extra demands for

such things as housing, transportation and time off.

2) Don't try to change methods of practice too quickly. If you ask, there probably are good reasons for the way medicine is practiced.

3) Don't make promises you can't keep. Your natural generosity may create disappointments. You can't always help everyone who needs it.

4) Don't complain about the lack of technology. If they had technology, they wouldn't need you.

If the idea of a working vaca-

tion intrigues you, write to Robert D. Robinson, M.D., Chairman, Department of Medicine, St. Vincent Hospital, 2001 W. 86th St., P.O. Box 40970, Indianapolis, IN 46240 for a complete list of organizations. Then get ready for the most meaningful vacation you and your family have ever had. □

The author is the chairman of the Department of Medicine and Director of Medical Education at St. Vincent Hospital and Health Care Center in Indianapolis.

■ drug names

Look-alike and sound-alike drug names

Category:	MESANTOIN Anticonvulsant
Brand name:	Mesantoin, Sandoz
Generic name:	Mephenytoin
Adverse reactions:	Ataxia, nystagmus
Dosage forms:	Tablets

Category:	CHYMEX Diagnostic aid
Brand name:	Chymex, Adria
Generic name:	Bentiromide
Adverse reactions:	Flatulence, heartburn, abdominal pain
Dosage forms:	Solution

Category:	MESTINON Cholinergic muscle relaxant
Brand name:	Mestinon, Roche
Generic name:	Pyridostigmine bromide
Adverse reactions:	Lacrimation, skin rash
Dosage forms:	Tablets, syrup, injection, sustained release tablets

Category:	CHOREX Chorionic gonadotropin
Brand name:	Chorex, Hyrex
Generic name:	Chorionic gonadotropin
Adverse reactions:	Headache, irritability, edema, depression
Dosage forms:	Powder for injection

Benjamin Teplitsky, R. Ph.
Brooklyn, N.Y.

Look-alike and sound-alike drug names can be misinterpreted by a nurse reading doctors' orders or by a pharmacist compounding physicians' prescriptions.

Such misunderstandings can result in the administration of a drug not intended by the prescriber. Awareness of such look-alike and sound-alike drug names can reduce potential errors. □

PCP presenting as cavitary pneumonia: A case report

Thomas G. Slama, M.D.
Linda Abels, M.D.
David Cox, M.D.
Indianapolis

Pneumocystis carinii (PC) is a common pathogen in patients with acquired immunodeficiency syndrome (AIDS) and is the most predominant life-threatening infectious pulmonary complication in this population. It usually occurs once in the course of this disease in more than 60% of AIDS patients.¹⁻⁴ PC, a saprophyte sporozoa, is widespread in the environment and propagates in the alveoli of immunocompromised people, producing a generalized pneumonia.^{5,6}

Because the number of AIDS patient is increasing, much attention has focused on atypical radiologic presentations of *Pneumocystis carinii* pneumonia (PCP). A spectrum of roentgenographic findings has been described with PCP even isolated from patients with a totally normal chest roentgenogram.^{6,7} Classically, PCP has been described as bilateral perihilar, basilar reticular or reticulonodular infiltrates with a diffuse ground glass appearance that coalesce into a pattern of consolidation with air bronchograms.^{2,5,7} Association with a unilateral or lobar infiltrate or with a necrotizing pneumonia has been reported.^{8,9} Isolated pleural effusions in the presence of PCP have also been documented.⁵

Abstract

As *Pneumocystis carinii* pneumonia cases increase, physicians must consider the various atypical radiographic presentations of the disease. The following case report illustrates one atypical presentation and the dramatic response to treatment.

Solitary pulmonary nodules⁵ or pleural based nodules¹⁰ have been identified, as have the presence of cystic changes, at times leading to spontaneous pneumothorax.^{1,11} The latter was thought to be the result of a disruption of alveolar lining, secondary to the necrosis and denudation of type I pneumocytes. This results in the development of interstitial air that dissects into the visceral and/or parietal pleura forming blebs that rupture. Thin walled cavitary lesions that may be seen in the apices and mimic granulomatous disease have also been described.^{10,12,13} Although previously associated with prior pentamidine treatment,¹⁴ large multiple cavitations due to PCP have been reported without previous pentamidine prophylaxis in an intravenous drug abuser.¹³

The following case report illustrates an atypical cavitary presentation of PCP.

Case report

A previously healthy 28-year-old, white, homosexual man was admitted to the hospital with a five-week history of cough, rhinorrhea,

malaise, fever, chills, night sweats and a 10-pound weight loss. One week before admission, his cough produced clear sputum, and he was diagnosed with oral thrush.

On admission, his only medication was a cough suppressant, and he had no known allergies. His medical history was significant for a case of herpes genitalis four months earlier and smoking.

Physical examination revealed a thin white man with an oral temperature of 101.6° F. His blood pressure was 123/67, heart rate was 136 and respiratory rate was 16. Other pertinent findings included oral thrush and the presence of rhonchi bilaterally in the basilar lobes.

The chest x-ray on admission (Figure 1) showed bilateral upper lobe cavitary infiltrates without evidence of pleural fluid or definite adenopathy. The room air oxygen saturation was 94%. The initial laboratory evaluation revealed hemoglobin, 11.2 gm/dL; hematocrit, 33.4%; platelets, 201,000; white blood cell (WBC), 9,200; and the mean corpuscular volume, 94. The chemistry profile was significant for a total protein



Figure 1: Chest radiograph on admission, demonstrating bilateral, upper lobe cavitory infiltrates.



Figure 2: Chest radiograph near the completion of therapy, illustrating the marked regression of cavitory infiltrates.

of 6.5 gm/dL, albumin of 2.9 gm/dL and lactic dehydrogenase of 243 mu/mL. All other initial laboratory test results were normal.

Because of the patient's sexual history, treatment was initiated with intravenous trimethoprim and sulfamethoxazole (TMP/SMX) on the day of admission for the presumptive diagnosis of PCP. Fiberoptic bronchoscopy, including transbronchial biopsy and bronchoalveolar lavage, was performed the following day. Cultures of these specimens were negative for acid-fast bacilli and fungal disease. Brushings and washings from both lung fields were positive for PC organisms only. Transbronchial biopsy specimens showed numerous Gomori methenamine silver-posi-

tive organisms consistent with PC.

The immunocompetency panel showed an absolute CD4 count of 20, absolute CD8 count of 90 and an absolute total WBC count of 2,500 with a helper:suppressor ratio of 0.25. The human immunodeficiency virus antibody (HIV) test was positive by Elisa and Western blot.

Shortly after the TMP/SMX treatment began, the patient's fever began to subside, and he had an uneventful recovery. A follow-up chest x-ray on the 12th day of therapy showed an improvement in the cavitory lesions. On the 18th day (*Figure 2*), it revealed further regression of the bilateral upper lobe cavitory infiltrates.

The patient received a total

dose of three weeks of TMP/SMX. He was discharged on azidothymidine (AZT) and prophylactic doses of oral TMP/SMX.

Discussion

The patient's clinical presentation and roentgenographic findings on admission suggested granulomatous disease including cavitory mycobacterium tuberculosis and histoplasma capsulatum. However, as previously described, he had PCP.

With the increasing number of people with PCP, physicians should be aware of the "nonclassic" presentations and, in the appropriate population, consider the diagnosis of PCP. Empiric treatment with TMP/SMX should be initiated while awaiting diagnostic confirmation from

transbronchial biopsy and bronchoalveolar lavage. This case also illustrates the unexpected and unusually rapid resolution of this disease process with the standard therapy. ▀

Correspondence and reprints:
Thomas G. Slama, M.D., Infectious
Disease of Indianapolis, 8424 Naab
Road, Suite 2D, Indianapolis, IN
46260.

Dr. Slama is a clinical associate professor of medicine at the Indiana University School of Medicine and chief of infectious diseases at St. Vincent Hospital in Indianapolis. Drs. Abels and Cox are internal medicine residents at St. Vincent Hospital.

References

1. Pinski R, Rogers LF: Roentgenograms of the month - Cystic parenchymal changes associated with spontaneous pneumothorax in an HIV-positive patient. *Chest*, 97:1471-1472, 1990.
2. DeLorenzo LJ, Huang CT, Stone DJ: Roentgenographic patterns of *Pneumocystis carinii* pneumonia in 104 patients with AIDS. *Chest*, 91:323-327, 1987.
3. Amorosa JK, Nahass RG, Noshier JL, Gocke DJ: Radiologic distinction of pyogenic pulmonary infection from *Pneumocystis carinii* pneumonia in AIDS patients. *Radiology*, 175:721-724, 1990.
4. Myung SS, Liendo C, Ho KJ: *Pneumocystis carinii* pneumonia in an AIDS patient: Unusual manifestation as multiple cavitary and non-cavitary peripheral pulmonary nodules and spontaneous pneumothorax. *Clin Imaging*, 13:225-227, 1989.
5. Heron CW, Hine AL, Pozniak AL, Swinburn CR, Johnson NMI: Radiographic features in patient with pulmonary manifestations of the acquired immune deficiency syndrome. *Clin Radiol*, 36:583-588, 1985.
6. Suster B, Akerman M, Orenstein M, Wax MR: Pulmonary manifestations of AIDS: Review of 106 episodes. *Thorac Radiol*, 161:87-93, 1986.
7. Goodman JL, Tashkin DP: *Pneumocystis* with a normal chest x-ray film and arterial oxygen tension. Early diagnosis in a patient with acquired immunodeficiency syndrome. *Arch Int Med*, 143:1981-1982, 1983.
8. Barrio JL, Suarez M, Rodriguez JL, Seldana MJ, Pilchenek AE: Case report: *Pneumocystis carinii* pneumonia presenting as cavitating and non-cavitating solitary pulmonary nodules in patients with acquired immunodeficiency syndrome. *Am Rev Respir Dis*, 134:1094-1096, 1986.
9. Milligan SA, Stulbarg MS, Gamsu G, Golden JA: *Pneumocystis carinii* pneumonia radiographically simulating tuberculosis. *Am Rev Respir Dis*, 132:124-126, 1985.
10. Shin MS, Liendo C, Ho K: *Pneumocystis carinii* pneumonia in an AIDS patient: Unusual manifestation as multiple cavitary and non-cavitary peripheral pulmonary nodules and spontaneous pneumothorax. *Clin Imaging*, 13:225-227, 1989.
11. Feuerstein IM, Archer A, Pluda JM, et al: Thin-walled cavities, cysts and pneumothorax in *Pneumocystis carinii* pneumonia: Further observations with histopathologic correlation. *Thorac Radiol*, 174:697-702, 1990.
12. Chechani V, Zaman MK, Finch PJP: Chronic cavitary *Pneumocystis carinii* pneumonia in a patient with AIDS. *Chest*, 95:1347-1348, 1989.
13. Conetta R, Kilstein S, Chitkara RJ: Cavitation as an unusual roentgenographic manifestation of *Pneumocystis carinii* in a patient with acquired immunodeficiency syndrome. *New York St J Med*, 88:652-653, 1988.
14. Edelstein H, McCabe RE: Atypical presentations of *Pneumocystis carinii* pneumonia in patients receiving inhaled pentamidine prophylaxis. *Chest*, 98:1360-1369, 1990.

YOCON[®]

YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

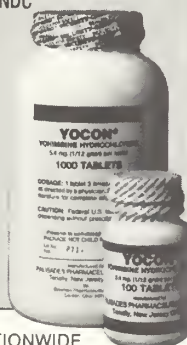
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence. 1,3,4 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

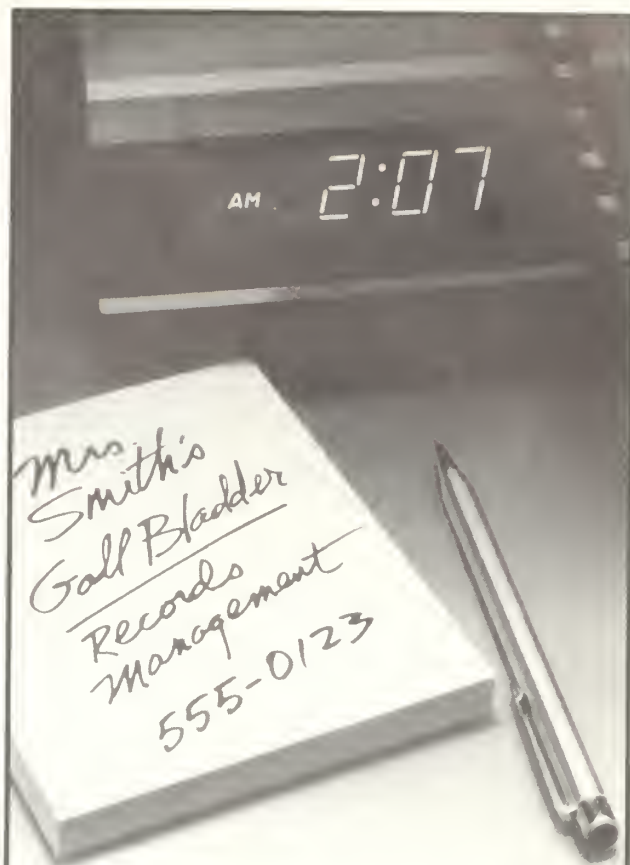
Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

**PALISADES
PHARMACEUTICALS, INC.**

219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083



If you are dedicated to health care why waste your time finding old files?

Current patient records should be at your fingertips. No question there. But what about old records, paid up bills and even dated x-rays? Consider offsite records storage. It can help clean up the office, and add to your efficiency. Your records are kept nearby in safe and secure storage facilities, for a low monthly fee. What if you need them in an emergency? With just a phone call our 24 hour, 365 day service can retrieve the needed file and fax it to you at the hospital, probably in the time it takes you to get there. Call in Records Management Services, and talk to the people that have been taking care of professional business records needs for over twenty-five years.



Records Management Services Corporation
Where business records are treated like treasure.

1165 South Girls School Road
Indianapolis, Indiana 46231
317.244.9044

■ auxiliary report

Incoming leaders receive training

Trudy Urgena
ISMA-Auxiliary President

Leadership development and training are vital functions of successful organizations. Recognizing the need for leadership skills training for state and county leaders, the ISMA-Auxiliary conducted several workshops with the assistance of a professional leadership development consultant. The ISMA-A Presidential Summits, hands-on learning experiences, prepared county presidents and presidents-elect to be confident leaders and developed their potential for success.

The summits also allowed

county leaders to explore current leadership concepts and discuss new organizational development strategies. County leaders learned skills to help build an effective county team, empower and motivate members, conduct well-attended efficient meetings, set achievable goals and develop creative project and program ideas. The summits, combined with the AMA-Auxiliary Leadership Confluences, have provided the newly installed county presidents with the confidence and skills to be effective leaders.

During their orientation meeting, the ISMA-A Board of Directors learned skills to prepare them to work as an effective team in meeting the needs of the membership. They also learned how to set achievable goals to gain momentum in steering the auxiliary into the 21st century.

Name change considered

This year the state auxiliary will consider a name change because the national organization has proposed a change from auxiliary to alliance. A name change study concluded that "auxiliary" connotes women, as well as subservience to a more important body, and may prevent potential members, especially men, young physicians' spouses and those with careers from choosing to belong to the organization.

The national organization worked closely with the AMA to identify what the name should communicate. To members and potential members, the name should convey:

- community health promotion
- concern about quality medical care
- partnership with the AMA
- strength in numbers
- concern for the medical family
- professionalism
- a wide range of capabilities
- the diversity of membership

To other audiences, the name should communicate:

- concern for the welfare of the community and other people
- involvement in community programs
- action orientation
- legislative action/involvement

The name should **not** convey the following: that the organization is social in nature; that its members are all women, all homemakers, all affluent; that its value comes only from members' relationships to their spouses; or that the organization is self-serving.

At the annual AMA-Auxiliary Convention held in June, the House of Delegates voted on changing the name to American Medical Association Alliance. Alliance was chosen because it is defined as "the state of being allied; a bond or connection between families, states, parties or individuals; an association to further the common interests of the members; union by relationship in qualities; affinity." According to the organization, the word "alliance" most closely describes what it is and does. □



Blindfolded Lee Ann Hughes, Howard County Auxiliary president, assembles a cardboard cup under the direction of handcuffed Pam Harris, Porter County Auxiliary president, in a team-building activity during the Presidential Summit.



SNAKEROOT E X T R A C T

PUBLISHED BY THE
 INDIANA MEDICAL HISTORY MUSEUM
 IN ASSOCIATION WITH
 THE INDIANA HISTORICAL SOCIETY

NUMBER 24

SUMMER 1992

MUSEUM REFURBISHES SKYLIGHTS, ROOF

The Indiana Medical History Museum last month began replacing the flat roof, refurbishing the skylights and making the other improvements to the museum's historic structure made possible by a \$10,000 matching grant.

The grant was awarded last year by the Indiana Department of Natural Resources' Division of Historic Preservation and Archaeology. The United States Department of the Interior provides the monies for this grant program through the Historic Preservation Fund.

The contractors began work on the flat roof after conducting various tests. The flat roof is located above the building's amphitheater on the rear portion of the historic structure.

The tests involved removing small patches of the rubber roofing and taking samples of the roof's deck. As a result, the contractors could determine whether any problems existed that the contractors should address before commencing the scheduled work.

While installing the new roof, the contractors also repaired the building's original skylights located in the amphitheater, ana-

tomical museum and photography laboratory. The repairs involved removing the glass from the skylights and refurbishing the various parts of the skylights' frames.

After installing the new roof and refurbishing the skylights, the contractors also relined and rebuilt the gutters in several locations along the flat roof. R. Adams Roofing, Inc., of Indianapolis, served as the

MUSEUM IMPROVES TEMPERATURE CONTROL

The Indiana Medical History Museum recently had installed automatic change-over thermostats in order to improve control over the interior temperature of the building.

The new thermostats eliminate the need to manually adjust the temperature control system each time the weather changes significantly. As a result, the museum now provides the constant temperature desired to preserve the museum's collections.

In addition, the new thermostats eliminate any human error that might occur in monitoring the temperature control system. Previously, a danger existed that appropriate personnel could not reach the museum during inclement weather to make the changes necessary to adjust the museum's interior temperature.

Chapman Heating and Air Conditioning, located in Indianapolis, completed the installation of the new thermostats in June. The installation represents one of several improvements to the museum's historic structure made possible by a \$10,000 matching grant.

The grant was awarded last year by the Indiana Department of Natural Resources' Division of Historic Preservation and Archaeology. The United States Department of the Interior provides monies for this grant program through the Historic Preservation Fund.

contractor for the work to the roof and skylights.

The improvements made possible by the matching grant also involved tuck-pointing any damaged masonry. Mid-Continental Restoration Company, Inc., a firm based in Fort Scott, Kan., provided the services for this portion of the work.



Contractor Bob Smith of R. Adams Roofing, Inc., (right) and architect Dale R. Harkins of Sites and Structures, Inc., examine the roof's deck after removing a small patch of rubber roofing. After completing the tests, the contractors began the installation of the new roof made possible by a \$10,000 grant awarded by the Indiana Department of Natural Resources.

HISTOLOGY LABORATORY AIDED STUDY OF MENTAL ILLNESS

The Central Indiana Hospital for the Insane (now called Central State Hospital) included among the well-equipped facilities of its Pathological Department a histology laboratory in which physicians could study the tissue of the brain and the central nervous system.

The histology laboratory, as well as the building's other laboratories, provided physicians with state-of-the-art facilities in which to study mental and nervous disorders. Central Indiana Hospital for the Insane, located in Indianapolis, opened its Pathological Department in 1896.

"I know of no other hospital for the insane in this country for which there has been supplied such grand facilities for studying the obscure and sad diseases that are found in all hospitals for the insane," noted Dr. U. O. B. Wingate after a visit to the Pathological Department in 1900. Dr. Wingate served on the Health Commission of Milwaukee, Wis., during the 1890s.

The equipment contained in the histology laboratory enabled physicians to better understand the effects of the disease process on the health of the cell. Using the tissue sections prepared in the histology laboratory and the pathological specimens maintained in the building's anatomical museum, the hospital pathologist and the medical staff members studied the physiological — or organic — manifestations of various mental and nervous disorders.

After performing an autopsy in the building's mortuary, a physician prepared a tray of study slides in the histology laboratory. Each slide contained a thin section of tissue taken from the brain or central nervous system.



"There is an abundance of light at each table, the . . . [electric] lamps being arranged so that they can be turned and held stationary in any position," noted an 1896 article in the *Indianapolis News* that described the new histology laboratory at Central Indiana Hospital for the Insane. As part of the Pathology Department, the histology laboratory enabled physicians to study the physiological — or organic — manifestations of various mental and nervous disorders.

The physician procured the tissue sections by using an instrument called a microtome. After removing tissue from the brain, the physician placed the tissue on a celluloid block, hardened the tissue with a coat of paraffin and sliced the tissue with the microtome.

Once the physician mounted the thin section of tissue on a microscope slide, the physician dipped the slide into a glass staining jar that contained the desired dye. With the assistance of the dye, the physician could use a microscope to observe the fine detail of the cellular structure of the tissue.

The histology laboratory contained "three tables for microscopical work, the microscope

being in a glass case beside each table," according to an article which appeared in the *Indianapolis News* on December 16, 1896. "There is an abundance of light at each table, the . . . [electric] lamps being arranged so that they can be turned and held stationary in any position."

By preparing and studying the tissue sections, the physician learned not only about the physiological manifestations of mental and nervous disorders but also about the techniques associated with histology.

[Sources: "The Old Pathology Building: The Indiana Medical History Museum's Most Priceless Artifact" (1987) by Katherine M. McDonell, and "Pathological Study — New Building and Equipment at the Central Hospital" (1896) from the *Indianapolis News*.]

Snakeroot Extract derives its name from the white snakeroot plant, which significantly impacted medical history in Indiana. Many early Hoosiers experienced milk sickness, a mysterious disease the cause of which remained unknown until the 1920s. At that time, physicians traced the disease to the white snakeroot, or rather, to the consumption of milk from cows that had grazed on the plant. The white snakeroot contains the poison tremetol.

The Indiana Medical History Museum publishes **Snakeroot Extract** in association with the Indiana Historical Society. Thus, the members of the museum and the members of the Indiana Historical Society (who request this publication) receive this newsletter. Individuals should direct inquiries about membership in the Indiana Historical Society to: Indiana Historical Society, 315 West Ohio Street, Indianapolis, IN 46202-3299, (317) 232-1882.

Interested individuals should submit items for publication and direct any inquiries about museum membership to: Oren S. Cooley, Indiana Medical History Museum, 3000 West Washington Street, Indianapolis, IN 46222-4055, (317) 635-7329.

VIRCHOW FOUNDED CELLULAR PATHOLOGY

The research and arguments advanced by German pathologist Rudolf Virchow (1821-1902) established the concept of cellular pathology — that disease occurs from disturbances in the structure and function of the body's cells.

Virchow first proposed this theory in 1858, when he published *Cellular-Pathologie*. In that treatise, he explained his theory about the continuity of cellular life — as he expressed in the aphorism "Omnis cellula e cellula."

That dictum stated that all cells originate from other cells. The theory displaced the previously accepted idea that cells developed by spontaneous generation from primitive body fluids.

In addition, Virchow described the body as an organized "cell-state in which every cell is a citizen." Consequently, disease was "merely a conflict of citizens in this state, brought about by the action of external forces."

These ideas began to shift the focus of pathology towards an understanding of the



Rudolf Virchow (1821-1902) proposed the idea of cellular pathology — that disease occurs from disturbances in the structure and function of the body's cells.

effects of the disease process on the health of the cell. As a result, pathologists began to view inflammations, tumor growths and degenerations in terms of their cellular relationships.

[Sources: *Medicine: An Illustrated History* (1978) by Albert S. Lyons, M.D., and R. Joseph Petrucelli, II, M.D., Ph.D., and *A History of Pathology* (1965) by Esmond R. Long.]

PHARMACEUTICAL COMPANIES DEVELOPED SCIENTIFIC, MANUFACTURING TECHNOLOGY

The pharmaceutical companies that arose during the 1800s not only helped to develop but also applied the manufacturing technology that eventually removed the traditional functions of procuring and compounding drugs from the prescription laboratories maintained by pharmacists.

Large-scale production of pharmaceutical chemicals in the United States began in 1786, when Christopher Marshall, Jr., and Charles Marshall, wholesale and retail druggists in Philadelphia, began extensively to produce muriate of ammonia and Glauber's salt. After 1825, the subsequent managers equipped the firm with a jacketed copper pan, a filter press and open furnaces, and began to specialize in solid extracts and other pharmaceutical products.

During the early 1800s, the establishment and development of several pharmaceutical companies made Philadelphia the most important center for manufacturing prescription products. For example, Rosengarten and Sons, founded in 1822, was the first company to produce quinine sulfate in the United States and then, later, began to manufacture morphine salts (in 1832), piperine (1833), mercurials and strychnine (1834) and codeine, bismuth and silver salts (1836).

However, the increased demand for pharmaceutical chemicals and products generated by the Civil War furthered the establishment and development of pharmaceutical companies. Frederick Stearns and Company of Detroit, for example, replaced its 12-foot-by-12-foot prescription laboratory in its pharmacy with a plant — equipped with steam power, milling machinery and extraction apparatus — that

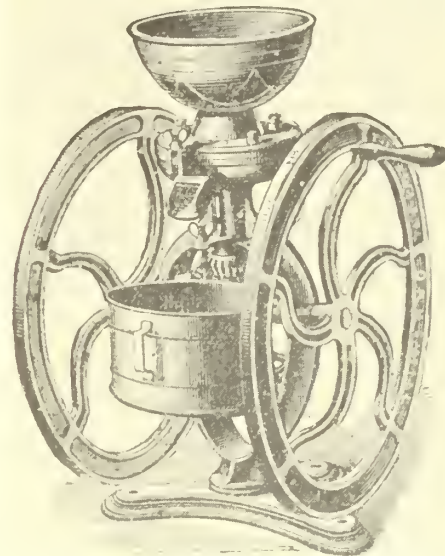
covered the entire floor space of a four-story building.

The technological advances that occurred between 1860 and 1880 also enabled pharmaceutical companies to manufacture prescription products that embodied the qualities of purity, uniformity and reliability that physicians desired for their therapeutic products. For example, E. R. Squibb and Sons of Brooklyn invented ways to prepare not only pure ether but also pure drugs and then made these improved products available for physicians to utilize or prescribe.

The growth of most large pharmaceutical companies usually involved the preparation initially of galenicals (often starting with fluid extracts), then expanded to the production of various chemicals and, eventually, progressed to the systematic production of biologicals after the turn of the century. Eli Lilly and Company of Indianapolis, for example, started in 1876 with the production of fluid extracts, syrups and pepsine preparations and then expanded its product line by 1915 to include anti-streptococcus serum and bacterial vaccine for typhoid.

As technological advances occurred during the late 1800s, most prescription laboratories maintained by pharmacies could not compete with the blandishments proffered by large pharmaceutical companies. Although prescription laboratories could adapt some innovations — such as improvements in percolation apparatuses that advanced the processes of drug extraction, most pharmacists never considered such adaptations very practicable for their laboratories.

The mass-production of parvules — or



Some pharmacists did adapt their prescription laboratories to accommodate some of the technological innovations that occurred during the 1800s, although most pharmacists never considered such adaptations very practicable. Enhanced drug mills, for example, enabled pharmacists to easily generate larger quantities of the very fine powders needed to prepare medications.

small pills — and the introduction of coated and compressed tablets also precluded the average prescription laboratories from producing many medications. Despite efforts to increase their education, many practicing pharmacists did not become well versed in producing these new drug forms until after local production had become scarcely feasible economically.

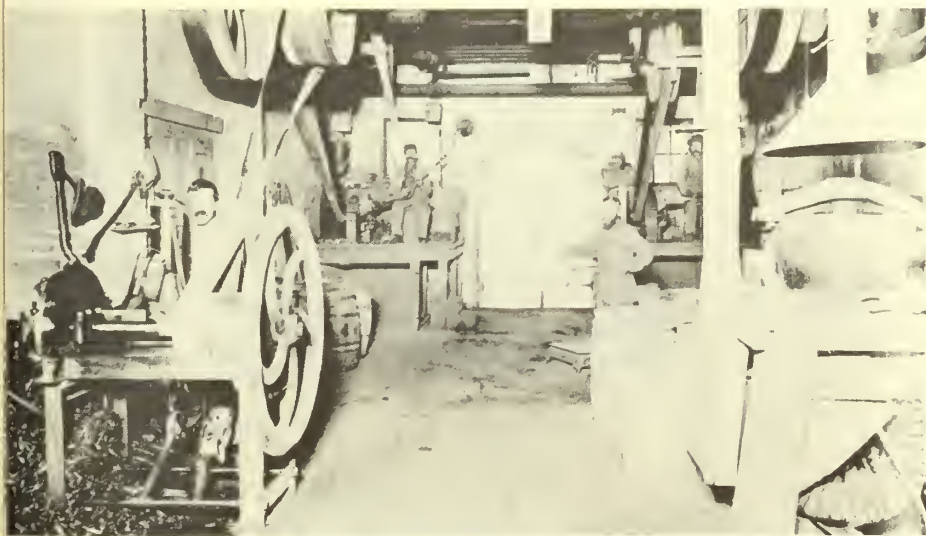
Although numerous pharmaceutical companies developed in the United States, most firms that produced medicinal chemicals and products were based in Germany. For example, Merck and Company of Rahway, New Jersey, began in 1891 as the American branch of E. Merck-Darmstadt, located in Darmstadt, Germany.

Many German companies, however, did not manufacture their products in the United States. Instead, the companies acquired patents that afforded the protection necessary to sell their products in America.

Germany remained the leading producer of pharmaceutical chemicals and products until World War I. During that time, legislation occurred in the United States that allowed the government to seize and sell the patents for various pharmaceutical products to companies based in the United States.

The Indiana Medical History Museum currently displays an exhibit on the history of pharmacy. Visitors to the museum may access the museum, located on the grounds of Central State Hospital, from the museum's entrance at 3045 West Vermont Street.

[Sources: Pharmacy: An Illustrated History (1990) by David L. Cowen and William H. Helfand, and [Edward] Kremers' and [George] Urdang's History of Pharmacy (1976) revised by Glenn Sonnedeker, Ph.D.]



Steam-powered machines allowed pharmaceutical companies to rapidly pulverize medicinal barks, roots and other plants and, then, to quickly grind those substances further into very fine powders. Such technological advancements quickly replaced the man-powered or horse-powered drug mills used during the early and middle 800s.

SWAMP ROOT SOLD WELL DURING PATENT MEDICINE ERA

Sales of Swamp Root — a cure-all nostrum — equalled about two million dollars a year during the height of the patent medicine era that occurred at the turn of the century.

Patent medicines were those cure-all nostrums the contents of which manufacturers kept secret. Most patent medicines, however, contained dangerous ingredients such as mercury, strychnine or large amounts of alcohol.

Although Swamp Root did not contain any mercury or strychnine, the elixir did contain about 10 percent alcohol. The manufacturers mixed the alcohol with the sweetened extracts of aloes, buchu leaves, oil of juniper, peppermint and venice turpentine.

The concoction purportedly cured not only liver, bladder and kidney diseases but also malaria, diabetes and poor appetite. "Swamp Root cured me when all else failed!" touted one circulated testimonial by D. H. Bilger of Hulmeville, Penn.

"La grippe [pneumonia] had settled in my kidney and liver, and I grew worse until I was a physical wreck, given up to die," exclaimed Bilger. "Father bought me a bottle of Dr. Kilmer's Swamp Root and before I had used all of the second bottle, I felt better. Today I am as well as ever."

Sylvester Andral Kilmer, M.D., (1841-1924) created Swamp Root at his sister's home near Binghamton, New York, during the middle 1870s. Initially, Dr. Kilmer sold Swamp Root on consignment to area drugstores.

After approaching bankruptcy three times, Dr. Kilmer acquired the assistance of his brother, Jonas, and his brother's son, Willis, during the early 1890s. Having studied advertising at Cornell University in Ithaca, New York, Willis implemented various schemes that achieved widespread notoriety for Swamp Root.

Besides packaging the elixir in an orange box for easier identification, Willis had melodic odes composed to sing the praises of Dr. Kilmer and his cure-all concoction. In addition, he had published various testimonials, guides of health and almanacs which bombarded the public with information about the alleged virtues of Swamp Root.

Unlike Dr. Kilmer, neither Jonas nor Willis believed in the efficacy of Swamp Root. By the middle 1890s, Jonas gained control of the business and, by implementing additional money-making schemes, eventually amassed between \$40 million and \$45 million.



Swamp Root purportedly cured not only liver, bladder and kidney diseases but also malaria, diabetes and poor appetite. The manufacturers mixed the elixir's 10-percent alcohol content with the sweetened extracts of aloes, buchu leaves, oil of juniper, peppermint and venice turpentine.



Indiana Medical History Museum
3000 West Washington Street
Indianapolis, IN 46222-4055
(317) 635-7329

INDIANA EMERGENCY MEDICINE

For the widest variety of practice opportunities in emergency medicine, look no further than Spectrum Emergency Care. With over 450 client facilities nationwide, you're certain to find a perfect match to your personal and professional goals.

Spectrum Emergency Care offers:

- ◆ Flexible scheduling
- ◆ Occurrence-based malpractice insurance
- ◆ Administrative support
- ◆ Guaranteed fees

To learn more about the many exciting opportunities currently available in Indiana, contact Dan Fuller at 800/325-3982, ext. 7809.

SPECTRUM
EMERGENCY CARE

A member of The ARA Group

RESIDENT ALERT : IF YOU COULD USE \$26,000 A YEAR— ANSWER THIS AD.

The U.S. Army's Financial Assistance Program (FAP) will subsidize training in certain specialties totaling over \$26,000 a year. Here's how it breaks down—a \$16,856

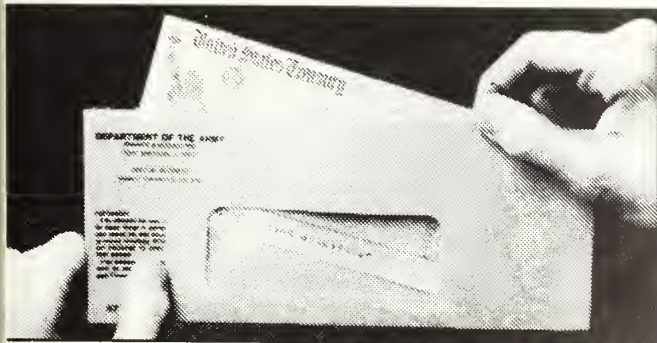
annual grant, \$794 monthly stipend and reimbursement of approved educational expenses. You may participate in this program for two years, and in return will serve three years as an Army medical officer.

You will be part of a unique health care team where you will find many opportunities to continue your education, work at state-of-the-art facilities, and receive outstanding benefits.

So, if you are a resident who could use over \$26,000 a year, contact an Army Medical Counselor immediately. Just call collect

CAPTAIN REGINALD L. BOOKER, MS
(708) 541-3411/3599

ARMY MEDICINE. BE ALL YOU CAN BE.



CARDIOLOGY - DIAGNOSTIC & INTERVENTIONAL



NASSER, SMITH AND PINKERTON CARDIOLOGY, INC.

William K. Nasser, M.D.

Michael L. Smith, M.D.

Cass A. Pinkerton, M.D.

James W. VanTassel, M.D.

Dennis K. Dickos, M.D.

John D. Slack, M.D.

Charles M. Orr, M.D.

Jane Howard, M.D.

James H. Adlam, M.D.

V. Michael Bournique, M.D.

Frank J. Green, M.D.

Nancy A. Branyas, M.D.

Charles P. Taliercio, M.D.

Bruce F. Waller, M.D.

Thomas F. Peters, M.D.

Lawrence E. Gering, M.D.

providing

Cardiology & Cardiac Catheterization

Transesophageal Echocardiography

Doppler & Echocardiography

Exercise Stress Testing

Coronary Angioplasty

Nuclear Cardiology

Pacemaker Surveillance

Holter Monitoring

Percutaneous Valvuloplasty

Electrophysiology Testing

Coronary Atherectomy

Myocardial Biopsy

Automatic Implantable

Cardioverter Defibrillator

Signal Averaged Electrocardiography

Nutrition Services

Cardiac Rehabilitation

Office: 317-871-6666

1-800-732-1482

1-800-CHD-PTCA

1-800-CAD-PTCA

FAX: 317-871-6019

With additional offices

located in:

Anderson • Brazil

Carmel • Kokomo

Marion • Terre Haute

Suite 400

St. Vincent Professional Building

8402 Harcourt Road

Indianapolis, Indiana 46260

THE HEART CENTER OF INDIANA

CARDIOLOGY

FORT WAYNE CARDIOLOGY

Basil C. Genetos, M.D.
Robert W. Godley, M.D.
Michael J. Mirro, M.D.
Kevin J. Kelly, M.D.
Fred Doloresco, M.D.
John F. Phillips, M.D.
Patrick J. Daley, M.D.
William W. Wilson, M.D.
James J. Heger, M.D.
Raymond E. Dusman, M.D.
Charles F. Presti, M.D.
Stephen E. Brown, M.D.
David D. Whang, M.D.

(Physician's Referral Only)

1912 Carew Street
Fort Wayne, Indiana 46805
(219) 482-4865 (800) 637-6505 (IN)
(800) 334-4371 (MI & OH)

Lutheran Medical Park
7900 W. Jefferson Blvd.
Suite 202
Fort Wayne, Indiana 46804
(219) 432-5613

Caring for people is the first priority at Fort Wayne Cardiology. Since 1978, our team approach has served referring physicians and their patients with the latest in heart care treatment and technologies.

Fort Wayne Cardiology is a trusted and caring group of people, featuring 13 board certified/board eligible cardiologists, as well as a special staff of nurses, technologists and administrative assistants. Patients are able to receive comprehensive cardiac services which include: cardiac catheterization, coronary angioplasty and atherectomy, electrophysiology, valvuloplasty, nuclear cardiology, doppler and echo cardiography, exercise stress testing, holter monitoring, ECG event monitoring, permanent pacemaker implantation and surveillance, non-invasive peripheral vascular evaluation, peripheral angioplasty and atherectomy, myocardial biopsy, transesophageal echo, AICD insertion and surveillance, signal average EKG, tilt table and rehab therapy.

University trained, certified cardiologists; the best in diagnostic equipment; clinical research and specialization within the specialty, makes Fort Wayne Cardiology an excellent center for heart care.

Angola
Auburn
Columbia City
Huntington

Kendallville
LaGrange
Wabash
Warsaw

Defiance, OH
Hicksville, OH

CARDIOLOGY

A new era in heart care has begun...

Now open



Robert E. Swint, Sr., M.D.

Mark A. Jones, M.D.

David A. Kaminskas, M.D.

Gary A. Hambel, M.D.

Mary H. Heintz, M.D.

Ravi N. Bathina, M.D.

Gregory C. Tomlinson, M.D.

Brian T. Lew, M.D.

Peter C. Hanley, M.D.

Christopher Zee-Cheng, M.D.

Steven W. Orlow, M.D.

David A. Belvedere, M.D.

Mark S. Hazen, M.D.

7836 W. Jefferson Blvd.

Fort Wayne, IN 46804

(219) 432-2297

800 Broadway, Suite 204

Fort Wayne, IN 46802

(219) 422-2558

3217 Lake Ave.

Fort Wayne, IN 46805

(219) 422-2297

2510 Dupont Rd.

Fort Wayne, IN 46825

(219) 489-8280

1-800-777-2297

CARDIOLOGY

Indiana Heart Physicians, Inc.

a member of the
Indianapolis Regional Heart Center
at St. Francis

Indianapolis/Beech Grove Medical Center
112 North 17th Avenue, Suite 300

Office	317-783-8800
Appointment Scheduling	317-781-3615
Cardiac Testing Center	317-781-3636
Toll Free (Nationwide)	800-992-2081

Consulting Offices at:

Greenwood
Shelbyville
Martinsville

Indiana Heart Physicians at Columbus
3154 North National Road, Suite C

Office	812-379-2020
Toll Free (Indiana)	800-331-4765

Physicians

H. O. Hickman, Jr., M.D., FACC
Thomas M. Mueller, M.D., FACC
J. Douglas Graham III, M.D., FACC
Kathleen H. Flohr, M.D., Ph.D., FACC
Jeffrey L. Christie, M.D., FACC
Stephen H. Kliman, M.D., FACC
Thomas C. Passo, M.D., FACC
Emily A. Diltz, M.D., FACC
John E. Batchelder, M.D., FACC
Mark D. Cohen, M.D., FACC
William J. Berg, M.D.
Thomas D. Hughes, D.O.
George E. Revtyak, M.D., FACC

at Columbus

David J. Hamilton, M.D., FACC
Kevin C. Preuss, M.D., FACC

providing

Cardiology and Cardiac
Catheterization
Coronary Angioplasty
Coronary Atherectomy
Electrophysiology
Percutaneous Valvuloplasty
Nuclear Cardiology
Stress Echocardiography
Exercise Stress Testing
Holter Monitoring
ECG Event Monitoring
Permanent Pacemaker Implantation
Pacemaker Surveillance
Color Flow Doppler Echocardiography
Laser Angioplasty
Trans-Telephonic Pacemaker Analysis

Noninvasive Peripheral
Vascular Evaluation
Signal Average EKG
Myocardial Biopsy
Tilt Table Testing

CARDIOLOGY



Indianapolis Cardiology Associates, Inc.

Robert E. Edmands, M.D., F.A.C.C.

Samuel M. Hazlett III, M.D.

Don B. Ziperman, M.D., F.A.C.C.

Bradley A. Weinberg, M.D.

are pleased to announce the association of

Richard A. Hahn, M.D.

for the practice of cardiology.

- Cardiology & Cardiac Catheterization
- Coronary Angioplasty
- Laser Angioplasty
- Coronary Atherectomy
- Echocardiography
- Transesophageal Echocardiography
- Color Flow Imaging
- Nuclear Cardiology
- Stress Testing
- Holter Monitoring
- Pacemaker Surveillance
- Permanent Pacemaker Implantation
- Evaluation of Cardiac Risk Factors
- Cardiac Rehabilitation Program

East Location

1400 N. Ritter Avenue, Suite 585

Indianapolis, Indiana 46219

Office~(317) 355-1500

Referring Physician Line~(317) 355-1100

North Location

7250 Clearvista Drive, Suite 227

Indianapolis, Indiana 46256

Office~(317) 841-5385

Referring Physician Line~(317) 841-5386

CARDIOLOGY

THE HEART CENTER OF MARION



Prakash N. Joshi, M.D., F.A.C.C.
Diplomate, American Board of
Internal Medicine & Cardiovascular
Diseases

Subodh S. Gupte, M.D., F.A.C.C.
Diplomate, American Board of
Internal Medicine, Cardiovascular
Diseases and Advanced Achievement
in Internal Medicine

providing
Cardiology
Electrocardiogram
Exercise Stress Testing
Doppler &
Echocardiography
Stress
Echocardiography
Holter Monitoring

**703 Chapel Pike
Marion, Indiana 45952**

**Appointments: (317) 664-1201
Business Office: 1-800-345-2035
FAX: (317) 664-2866**

Nasser, Smith & Pinkerton Cardiology, Inc.

DOCTORS

These spaces are available.

For rates, write or call
INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-4762.

DOCTORS – This space is available.

For rates, write or call INDIANA MEDICINE,
322 Canal Walk, Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

DOCTORS – This space is available.

For rates, write or call INDIANA MEDICINE,
322 Canal Walk, Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

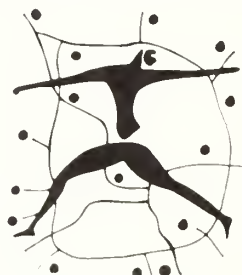
PLASTIC, RECONSTRUCTIVE & HAND SURGERY

One Call, Day or Night!

Our group is always available, 365 days a year, day or night; to see your patients in Indianapolis because there are times when your patient shouldn't have to wait.

ALSO SEEING PATIENTS
BY APPOINTMENT IN THESE
CENTRAL INDIANA CITIES:

BEECH GROVE
CRAWFORDSVILLE
DANVILLE
GREENCASTLE
GREENSBURG
KOKOMO
LEBANON
MOORESVILLE
SURGERY CENTER



SERVING 15 CENTRAL
INDIANA HOSPITALS

VISA, MASTERCARD ACCEPTED
FINANCING AVAILABLE

ZOLLMAN CENTER FOR PLASTIC & HAND SURGERY

7439 Woodland Drive, Indianapolis, IN 46278



Member, American Society
of Plastic and Reconstructive Surgeons

317-328-1100
1-800-332-3943
FAX: 317-328-6948

Wally Zollman M.D., F.A.C.S., Twatchai Yamcharern M.D., F.A.C.S., Richard S. Troiano M.D., F.A.C.S.

PLASTIC SURGERY

MERIDIAN PLASTIC SURGERY CENTER

For information on services
317/575-0110
or 800/352-7849
106th & Meridian Streets
Indianapolis



An Ambulatory Surgery Center
Exclusively for Cosmetic, Plastic
and Reconstructive Surgery

Board-Certified Physicians

- Stephen W. Perkins, MD, FACS
- William R. Nunery, MD, FACS
- Ronald T. Martin, MD
- A. Michael Sadove, MD, FACS
- Barbara Siwy, MD

Facial, Ophthalmic & General
Plastic Surgery • Anesthesiology
Licensed by the Indiana State
Board of Health • Medicare
Certified

PLASTIC SURGERY



AMERICAN SOCIETY OF
PLASTIC & RECONSTRUCTIVE
SURGEONS, INC.

John G. Pantzer Jr., M.D., F.A.C.S.
Diplomate, American Board
of Plastic Surgery

1801 North Senate Blvd., Suite 735
Indianapolis, Indiana 46202
317-929-5500

RADIOLOGY

SUPERB QUALITY DIAGNOSTIC RADIOLOGY AND RADIATION ONCOLOGY SERVICES ARE ONLY A TELEPHONE CALL AWAY...

Our mission is to provide caring, high quality, state-of-the-art imaging, interventional, and radiation oncological services to our patients, referring clinicians, and institutions. Call us today to discuss your unique requirements or to refer your patients for prompt, courteous, cost effective, and professional service.

INDIANAPOLIS

Methodist Hospital
1701 N. Senate Avenue
Methodist Professional Center
1801 North Senate Avenue
(317) 929-3580

Methodist Hospital Breast Cancer
Screening Program
(317) 929-5000

Eagle Highlands Radiologic Services
6920 Parkdale Place
Suite 111
(317) 291-4411

Lakeview Radiologic Services
9002 North Meridian Street
Suite 110
(317) 844-6944

BROWNSBURG

Brownsburg Radiologic Services
1375 North Green Street
Suite 200
(317) 852-3222



COLUMBUS

(Radiation oncology only)
Bartholomew County Hospital
2400 East Seventeenth Street
(812) 376-5361

CRAWFORDSVILLE

Culver Union Hospital
1710 Lafayette Road
(317) 364-3146

GREENSBURG

Decatur County Memorial Hospital
720 North Lincoln Street
(812) 663-1156

KOKOMO

(Radiation oncology only)
Howard Community Hospital
3500 South Lafountain Street
(317) 453-8189

TERRE HAUTE

(Radiation oncology only)
Union Hospital
1606 North Seventh Street
(812) 238-7504



RADIOLOGIC SPECIALISTS OF INDIANA, INC.

All Physicians Board Certified.

CLINICAL & ANATOMIC PATHOLOGY

The Medical Laboratory

of Drs. Thornton-Haymond-Costin-Buehl-Bolinger-Warner-McGovern-McClure-Hooker-Winkler
5940 West Raymond Street • Indianapolis, Indiana 46241

CHEMISTRY
MICROBIOLOGY
HEMATOLOGY
TOXICOLOGY
CYTOLOGY
HISTOLOGY
CUSTOMER SERVICE



Courier Service
24 hr. Pathology
Consultation
Assignment Accepted:
Medicare/Medicaid
BC/BS VIP and PC/USA,
Preferred Care, Prucare
18 Convenient Branch
Locations

CENTRAL TESTING FACILITY: 5940 W. Raymond St., Indianapolis, IN 46241
Phone: 317/248-2448

"Here Today To Serve You Tomorrow."

DOCTORS

This space is available.

For rates, write or call
INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

PULMONARY DISEASE

RESPIRATORY CONSULTANTS OF INDIANA

DAVID B. COOK, M.D., FCCP
CHRIS C. NAUM, M.D.

MICHAEL R. NIEMEIER, M.D., FCCP
THOMAS Y. SULLIVAN, M.D.
JOHN A. WARDEN, M.D., FCCP

ROBERT W. WELLER, M.D., FCCP
PATRICK E. WRIGHT, M.D., FCCP

Pulmonary Disease

Lung and lung-heart transplantation
Laser Bronchoscopy
Intra-bronchial radiation therapy
Trans-tracheal oxygen therapy
Complete rest and exercise
physiologic testing

Critical Care

Physicians ABIM certified in
critical care 24 hours/day
State-of-the-art eighty bed
intensive care facility

Hyperbaric Medicine

Diagnostic assessment
of local oxygen delivery
Treatment of disorders of
regional O₂ delivery and
utilization

Sleep Disorders

Clinical polysomnographer
Full-service polysomnography
laboratory

1801 N. SENATE BLVD., SUITE 400, INDIANAPOLIS, IN 46202 • OFFICE (317) 929-5820 • FAX (317) 929-3916
6920 PARKDALE PLACE, SUITE 215 • INDIANAPOLIS, IN 46254 • OFFICE (317) 328-6635 • FAX (317) 328-6640
GREENSBURG (812) 653-5533 • LEBANON (317) 873-2103 • RUSHVILLE (317) 932-4111 • TERRE HAUTE (812) 232-0564
AFTER HOURS: ANSWERING SERVICE (317) 926-3466 OR 1-800-772-7788

1-800-321-LUNG • MONDAY - FRIDAY 8:30 A.M. - 4:30 P.M.

ALCOHOLISM TREATMENT

Eugene G. Roach, M.D.
Executive/Medical Director



Anderson Center
of Saint John's
2210 Jackson Street
Anderson, Indiana 46016

1-800-435-9143 or (317) 646-8383

- Comprehensive Alcohol and Drug Treatment
- Separate Programs for Adolescents and Adults
- Free Assessment and Intervention

DOCTORS

This space is available.

For rates, write or call

INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

INTERNAL MEDICINE

NEPHROLOGY & INTERNAL MEDICINE, INC.

Thomas Wm. Alley, M.D., FACP
George W. Applegate, M.D.
Richard Bochi, M.D.
Charles B. Carter, M.D.
William H. Dick, M.D., FACP
Theodore F. Hegeman, M.D.
Douglas F. Johnstone, M.D.
Wendy L. Kindig, M.D.
LeRoy H. King, Jr., M.D., FACP
Mary A. Margolis, M.D.
Tim E. Taber, M.D.

**1801 N. Senate Blvd., Suite 355
Indianapolis 46202
Tel: 317-924-8425**

By Physician Referral

Critical Nephrology, Hemodialysis, Peritoneal Dialysis, Renal Transplantation, Metabolic Kidney Stone Disease, Hypertension, Fluid and Electrolyte Imbalance, Critical Care

HEMODIALYSIS

CHRONIC MAINTENANCE OUTPATIENT HEMODIALYSIS

DIALYSIS INSTITUTE OF ANDERSON

2629 Nichol Avenue
Anderson, Indiana 46011
317-649-0772

DIALYSIS INSTITUTE OF BEECH GROVE

3834 South Emerson Avenue
Indianapolis, Indiana 46203
317-787-3171

For further information contact
NEPHROLOGY & INTERNAL MEDICINE, INC.

1801 N. Senate Blvd., Suite #355
Indianapolis, Indiana 46202
317-924-8425

Outpatient renal consultation may be
scheduled at any location.

HAND SURGERY

JOHN C. KLEIN, M.D.

Specializing in the diagnosis and treatment of hand, wrist, and forearm disorders.

2727 N. Pennsylvania St. 317-925-1665
Indianapolis, IN 46205 Answered 24 hours

Diplomate American Board of Orthopedic Surgery
with certificate of added qualifications in surgery of the hand.

HAND SURGERY

SOUTH INDY HAND CENTER, P.C. VIDYASAGAR S. TUMULURI, M.D., F.A.C.S.

CERTIFIED IN HAND SURGERY
Practicing hand and wrist surgery

South Sherman Professional Complex
3417 S. Sherman Dr., Suite F
Beech Grove, IN 46107
(317) 783-1319

Community Hospital South Prof. Bldg.
1550 E. County Line Rd., Suite 315
Indianapolis, IN 46227
(317) 888-0004

DERMATOPATHOLOGY

DERMATOPATHOLOGY LABORATORY

Larry J. Buckel, M.D.
Robert M. Hurwitz, M.D.

Howard R. Gray, M.D.
William B. Moores, M.D.



Diplomates of the American Boards
of
Dermatology and Dermatopathology

Specializing in
Inflammatory Skin Diseases
and
Neoplasms of the Skin

9202 North Meridian Street
Suite 215

Approved for and Accept
Medicare and Medicaid
Assignment

Indianapolis, Ind. 46260
(317) 843-2204

UPS Mailers and Courier Service Available

PSYCHIATRY

Eugene G. Roach, M.D.
Executive/Medical Director



Anderson Center

of Saint John's
2210 Jackson Street
Anderson, Indiana 46016

1-800-435-9143 or (317) 646-8114

- Comprehensive Psychiatric Treatment
- Separate Programs for Adolescents, Adults and Older Adults
- Program for Dual Diagnosis

NEUROLOGY

Shirley M. Mueller, M.D.
General Neurology

Practice Dedicated Toward Problems Associated With
Numbness-Weakness-Dizziness And Pain Including Headache

Testing Available

North: St. Vincent's Professional Bldg., Suite 726, Indianapolis
Tuesday, Thursday & Friday • 317-871-6000

South: Community South Professional Bldg., Suite M, Indianapolis
Monday & Wednesday • 317-887-7790

PERIPHERAL VASCULAR SURGERY



VASCULAR SURGERY, P.C.

Vascular
Diagnostics
— Mobile
— Non-invasive
— Testing
™

Austin L. Gardner, M.D.
Malcolm B. Herring, M.D.
Daniel R. LeGrand, M.D.
David L. Madison, M.D.
Spencer F. Goodson, M.D.
Sajjad M. Hussain, M.D.

St. Vincent Professional Building
8402 Harcourt Road
Suite 613
Indianapolis, Indiana 46260
Telephone (317) 871-6400
TOLL FREE (800) 662-5367

Carmel Medical Center
13450 North Meridian Street
Suite 160
Carmel, Indiana 46032
Telephone (317) 573-7040
TOLL FREE (800) 446-0298



The Vascular Lab

NONINVASIVE VASCULAR TESTING

The vascular lab offers a full spectrum of diagnostic vascular testing services, including the new addition of color computed sonography, supported by the entire team of:

John F. Ansbro, M.D. • Alan T. Marty, M.D. • H. Dan Adams, M.D.
Richard A. Murrell, M.D. • Daniel B. Daniels, M.D. • Jay Tuna, M.D.

Cardiovascular Surgery Inc.

350 West Columbia
Suite 350
Evansville, Indiana 47710
812-423-2395

■physicians' directory

ASTHMA & ALLERGY

FRANK WU, M.D.



DIPLOMATE,
AMERICAN BOARD
OF ALLERGY &
IMMUNOLOGY

St. Vincent Professional Building
8402 Harcourt Road, Suite 606
Indianapolis, Indiana 46260
(317) 872-4213

ORTHOPAEDIC SURGERY

JAMES L. KAISER, M.D.



- ORTHOPAEDIC SURGERY
- FRACTURES
- BACK SURGERY
- FOOT SURGERY
- ARTHROSCOPIC SURGERY

Certified American Board
Of Orthopaedic Surgery

5626 East 16th Street
Indianapolis, IN 46218

(317) 352-0176

OFFICE ANSWERS DAY & NIGHT

5626 E 16
82nd & Shadeland
If No Answer Call

352-0176
352-0176
543-6089

ONCOLOGY



Oncology Associates

Michael A. Cross, M.D.

Board Certified, Radiology (Therapeutic)

John R. Pancoast, M.D.

Board Certified, Internal Medicine
and Medical Oncology/Hematology

John F. Sacco, M.D.

Board Certified, Internal Medicine
and Radiology (Therapeutic)

Offering comprehensive cancer care, including:

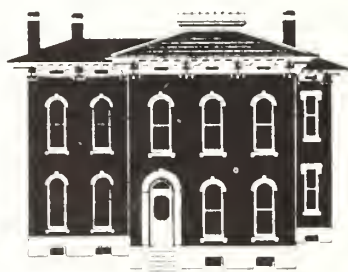
- Cancer Detection
- Chemotherapy
- Radiation Therapy (Linear Accelerator)
- Biologic Therapy
- Education and Support Services
- Hospital, Home and Hospice Care

Dearborn County Hospital Professional Building
606 Wilson Creek Road, Suite 130
Lawrenceburg, Indiana 47025
(812) 537-1911

Oncology Associates' 16 physician members have additional offices in Cincinnati, Montgomery and Middletown, Ohio, and Crestview Hills, Kentucky. The practice offers outpatient care and clinics in 11 hospitals throughout the Tri-State area.

ONCOLOGY — HEMATOLOGY

**INDIANA ONCOLOGY HEMATOLOGY
CONSULTANTS**



1-800-ONC-HEME
1-800-662-4363

Central: 317-927-5770
St. Francis: 317-783-8509

ADULT ONCOLOGY HEMATOLOGY — CENTRAL OFFICE

1828 N. Illinois Street Indianapolis, IN 46202 927-5770

Laurence H. Bates, M.D.
William M. Dugan, Jr., M.D.
Redmond P. Hogan, III, M.D.

Gregory W. Smith, M.D.
William H. Bond, M.D.

PEDIATRIC ONCOLOGY HEMATOLOGY — CENTRAL OFFICE

1828 N. Illinois Street Indianapolis, IN 46202 927-5770

Arthur J. Provisor, M.D.

Deborah S. Provisor, M.D.

ADULT ONCOLOGY HEMATOLOGY — ST. FRANCIS OFFICE

1600 Albany — Medical Clinic Bldg. Beech Grove, IN 46107 783-8509

Redmond P. Hogan, III, M.D. Randall C. Trowbridge, M.D.
Gregory W. Smith, M.D.

*Central Office Located in the Byram Gates Middleton House
Listed on the National Register of Historic Places*

RADIATION ONCOLOGY



Physicians:
ROGER ROBISON
TAE CHUNG

Radiation Oncology Services for Southwest Indiana

VINCENNES
Good Samaritan Hospital
(812) 885-3939

TERRE HAUTE
Regional Hospital
(812) 237-9326

ROGER ROBISON, M.D., F.A.C.P.
M.D. Anderson, 1980
Certified: Radiation
Oncology
Medical Oncology

TAE CHUNG, M.D.
Chicago Hines, V.A., 1976
Certified: Radiation
Oncology

RADIATION ONCOLOGY

TRI-STATE RADIATION ONCOLOGY

Evansville Cancer Center
Evansville, Indiana
(812) 474-1110



Welborn Cancer Center
Evansville, Indiana
(812) 426-8373

AL KORBA, M.D.; ALY RAZEK, M.D.
SHANNON LAMB, M.D.; PRAMOD V. PRABHU, M.D.

★ ★ ★ ★ ★

Tri-County Cancer Care Center
Jasper, Indiana
(812) 482-2212
DEVIDAS SHETH, M.D.

Tri-County Cancer Care Center
Princeton, Indiana
(812) 386-6663
MOISES DOMINGO, M.D.

★ ★ ★ ★ ★

Olney Cancer Center
Olney, Illinois
(618) 392-3050
MOISES DOMINGO, M.D.

Harrisburg Oncology Associates
Harrisburg, Illinois
(618) 252-5126
MANJU GUPTA, M.D.

★ ★ ★ ★ ★

Radiation Oncology
Owensboro, Kentucky
(502) 926-7228
TRISTAN BRIONES, M.D.

Henderson Cancer Center
Henderson, Kentucky
(502) 827-0255
PRAMOD V. PRABHU, M.D.

★ ★ ★ ★ ★

In Indiana 1-800-843-7117 • Out of Indiana 1-800-331-9294
24-hour answering service (812) 476-1367

TRANSPLANTATION

*Transplantation offers patients
with end-stage organ disease their only
opportunity for true rehabilitation...*

Methodist Transplant Center
24-hour referral: 800 772-7788



The Difference is Experience

P.O. Box 1367
1701 N. Senate Blvd.
Indianapolis, Indiana 46206

Heart Transplantation

Surgical Director: **Harold Halbrook, M.D.**

Surgeons: John Fehrenbacher, M.D.,
Daniel Beckman, M.D., David Hormuth, M.D.
Program Cardiologist: Douglas Pitts, M.D.

Kidney Transplantation Pancreas Transplantation

Surgical Director: **Brian Haag, M.D.**

Surgeons: Larry Stevens, M.D.,
Dale A. Rouch, M.D.
Program Nephrologist: Charles Carter, M.D.

Lung Transplantation

Surgical Director: **Harold Halbrook, M.D.**

Surgeons: John Fehrenbacher, M.D.,
Daniel Beckman, M.D., David Hormuth, M.D.
Program Pulmonologist:
Michael Niemeier, M.D.

Liver Transplantation

Surgical Director: **Dale A. Rouch, M.D.**

Surgeons: Larry Stevens, M.D.,
Brian Haag, M.D.
Program Pediatric Gastroenterologist:
Susan Maisel, M.D.
Program Hepatologist: Stephen C. Pappas, M.D.

Bone Marrow Transplantation

Co-Director: Luke Akard, M.D.
Co-Director: Jan Jansen, M.D., Ph.D.

Corneal Transplantation

Surgical Director: Stephen Johnson, M.D.

Tissue/Bone Bank

Surgical Director: David A. Fisher, M.D.

ORTHOPAEDIC SURGERY

TRADITION



ORTHOPAEDICS INDIANAPOLIS

*"CELEBRATING THREE DECADES
OF ORTHOPAEDIC EXCELLENCE"*

DONALD S. BLACKWELL, M.D.
F.R. BRUECKMANN, M.D., F.A.C.S.
ANTHONY R. LASICH, M.D.
WILLIAM O. IRVINE, M.D.
JOSEPH C. RANDOLPH, M.D.
DONALD E. RUSSELL, M.D.
MARK R. STEVENS, M.D.
TERRY R. TRAMMELL, M.D.
ANDREW J. VICAR, M.D.
VINCENT L. FRAGOMENI, M.D.
JOHN K. SCHNEIDER, M.D.
JOSEPH R. BAELE, M.D.
SANFORD S. KUNKEL, M.D.
DAVID A. FISHER, M.D.
D. KEVIN SCHEID, M.D.
MICHAEL F. COSCIA, M.D.
DEAN C. MAAR, M.D.
DAVID S. BROKAW, M.D.
HENRY G. STEIN, M.D., F.A.C.S.
ORTHOPAEDIC SURGEONS
ROBERT C. GREGORI, M.D.
PHYSICAL MEDICINE & REHABILITATION

JOINT RECONSTRUCTION

TRAUMA

FRACTURE CARE

SPORTS MEDICINE

SCOLIOSIS

SPINAL SURGERY

SHOULDER SURGERY

HAND SURGERY

FOOT SURGERY

ARTHROSCOPIC SURGERY

PEDIATRIC ORTHOPAEDICS

ADULT ORTHOPAEDICS

ILIZAROV LIMB LENGTHENING & DEFORMITY CORRECTION

ORTHOPAEDICS INDIANAPOLIS

1801 N. SENATE, SUITE 200

INDIANAPOLIS, IN 46202

317-923-5352

1-800-223-3381

FAX: 317-924-0115

INDIANAPOLIS•

ZIONSVILLE•DANVILLE

SPEEDWAY•GREENCASTLE

ORTHOPAEDICS & SPORTS MEDICINE

Hoosier Orthopaedics & Sports Medicine, P.C.

The Foot Program staff medically manages common foot problems such as:

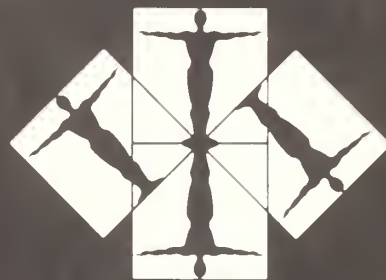
Ingrown Toenails
Mortons Neuroma
Hammer Toes
Bunions
Bunionette
Foot Strain
Soft Corns
Corns
Calluses
Planter Warts

Special emphasis on diabetic and rheumatoid arthritis foot problems. The services of a Pedicurist are available by appointment.

Office Answers Day and Night

13450 North Meridian Street, Suite 355, Carmel, Indiana 46032
(317) 575-2705

8330 Naab Road, Suite 234, Indianapolis, Indiana 46260
(317) 870-7075



Robert M. Palmer, M.D.

Frank B. Throop, M.D.

Robert T. Clayton, M.D.

Robert E. Cravens, M.D.

John E. Garber, M.D.

Thomas F. Trainer, M.D.

COMPREHENSIVE REHABILITATION

We're Working to Make Life Better

At Kokomo Rehabilitation Hospital, we're committed to only one specialized field – rehabilitation medicine.

This central focus means your patients receive the therapy and care needed to restore their lives to the fullest extent possible.



**Kokomo
Rehabilitation
Hospital**

Our newly opened, 60-bed hospital features sophisticated high-tech equipment, a total barrier-free environment and highly trained therapists.

Give us a try. Your patients and you will be pleased with the results.

– William J. Lester, MD,
Medical Director

Bringing the Quality Back to Life for Patients Affected by:

Stroke • Traumatic Brain Injury • Spinal Cord Injury • Amputation • Orthopedic Disorders • Neurological Disorders • Arthritis • Back and Neck Injuries • Chronic Pain • Multiple Trauma • Return to Work
• Carpal Tunnel Syndrome and other Cumulative Trauma Disorders

829 Dixon Road • Kokomo, Indiana 46901
General Hospital Information
(317) 452-6700

For Referral or Admission Information
1-800-886-LIFE

A Continental Medical Systems Facility

DOCTORS

This space is available.

For rates, write or call

INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

MULTI-SPECIALTY GROUP PRACTICE

Addictionology
Allergy
Cardiovascular Diseases
Dermatology
Endocrinology
Family Practice
Gastroenterology
Gynecology
Hematology-Oncology
Internal Medicine
Neurology
Nephrology
Nuclear Medicine
Obstetrics
Ophthalmology
Orthopedics
Otolaryngology
Pediatrics
Psychiatry
Pulmonary Medicine
Rheumatology
Surgery
Urology



**Welborn
Clinic**

421 Chestnut Street
Evansville, Indiana 47713
(812)426-9440

Toll-free in Indiana:
1-800-521-0269

Westside Family Practice Ctr.
(812)429-1818

Welborn Clinic East
(812)474-7123

Welborn Clinic Highland
(812)426-9565

In Newburgh:
Welborn Clinic Newburgh
(812)853-7391

In Reo:
Reo Family Practice Center
(812)649-5061

■ from the museum

Pharmaceutical companies that arose during the 1800s not only helped to develop but also applied the manufacturing technology that eventually removed the traditional functions of procuring and compounding drugs from the prescription laboratories maintained by pharmacists.

Large-scale production of pharmaceutical chemicals in the United States began in 1786, when Christopher Marshall Jr. and Charles Marshall, wholesale and retail druggists in Philadelphia, began to produce muriate of ammonia and Glauber's salt. After 1825, the firm was equipped with a jacketed copper pan, a filter press and open furnaces and began specializing in solid extracts and other pharmaceutical products.

During the early 1800s, the establishment and development of several pharmaceutical companies made Philadelphia the most important center for manufacturing prescription products. For example, Rosengarten and Sons, founded in 1822, was the first company to produce quinine sulfate in the United States and began to manufacture morphine salts in 1832, piperine in 1833, mercurials and strychnine in 1834 and codeine, bismuth and silver salts in 1836.

However, the increased demand for pharmaceutical chemicals and products generated by the Civil War furthered the development of pharmaceutical companies. For example, Frederick Stearns and Co. of Detroit replaced its 12-foot-by-12-foot prescription laboratory in its pharmacy with a plant that was equipped with steam power, milling machinery and extraction apparatus and that covered the entire floor space of a four-story

building.

The technological advances that occurred between 1860 and 1880 also enabled pharmaceutical companies to manufacture prescription products that embodied the qualities of purity, uniformity and reliability that physicians wanted in their therapeutic products. E. R. Squibb and Sons of Brooklyn invented ways to prepare not only pure ether but pure drugs and made these improved products available to physicians.

The growth of most large pharmaceutical companies usually involved the preparation initially of galenicals (often starting with fluid extracts), then expanded to the production of various chemicals and, eventually, progressed to the systematic production of biologicals after the turn of the century. Eli Lilly and Co., for example, started in 1876 with the production of fluid extracts, syrups and pepsine preparations and expanded its product line by 1915 to include antistreptococcus serum and bacterial vaccine for typhoid.

As technological advances occurred during the late 1800s, most prescription laboratories maintained by pharmacies could not compete with the blandishments offered by large pharmaceutical companies. Although prescription laboratories could adapt some innovations, most pharmacists never considered such adaptations practical for their laboratories.

The mass production of parvules, or small pills, and the introduction of coated and compressed tablets also precluded the average prescription laboratories from producing many medications. Despite efforts to increase their education, many practicing pharmacists did not become well-versed in producing these new drug forms until after local pro-

duction had become scarcely feasible economically.

The Indiana Medical History Museum in Indianapolis currently displays an exhibit on the history of pharmacy. Visitors may access the museum, located on the grounds of Central State Hospital, from the museum's entrance at 3045 W. Vermont St. or the hospital's entrance on Warman Street. □



Physicians initially used sodium salicylate compound, produced by Eli Lilly and Co., as an antipyretic to reduce rheumatic fever.

\$30,000 BONUS OFFERED TO HEALTH CARE PROFESSIONALS

If you are a board-certified physician or a candidate for board certification in one of the following specialties, you may qualify for a bonus of up to \$30,000 in the Army Reserve.

**Anesthesiology • General Surgery • Thoracic Surgery
Pediatric Surgery • Orthopedic Surgery
Colon-Rectal Surgery • Vascular Surgery • Neurosurgery**

A test program is being conducted which offers a bonus to eligible physicians who reside in certain geographic areas (Pennsylvania, West Virginia, Ohio, Michigan, Illinois, Indiana, Wisconsin, Minnesota and Iowa). You would receive a \$10,000 bonus for each year you serve as an Army Reserve physician—for a maximum of three years.

You may serve near your home, at times convenient for you, or at Army medical facilities in the United States and abroad. There are also opportunities to attend conferences and participate in special training programs, such as the Advanced Trauma Life Support Course.

To learn more about the Army Reserve and the Bonus Test Program, call one of our experienced Medical Personnel Counselors:

CAPTAIN GEORGE HUGGINS — CALL COLLECT (317) 542-3759

ARMY RESERVE. BE ALL YOU CAN BE.

Auto Buyers Network

The #1 priority at Auto Buyers Network is to provide you with an easy, timely, and affordable way to purchase your next new or used car, truck or van. Tell us the make and model vehicle that you prefer and **we** do the legwork. No more disputing with salesmen, wondering and worrying if you're getting a "good deal." We can even arrange leasing or financing utilizing the best rates available from several participating lenders.

▲ Personalized Service Statewide ▲

Auto Buyers Network

Bill Prewitt, ISMA Consultant

40 West 40th Street, Indianapolis, IN 46208

317/ 921-1537 or 800/736-0172

■ cme calendar

St. Vincent Hospital

St. Vincent Hospital and Health Care Center in Indianapolis will sponsor these CME courses:

July 18 - Second Annual Symposium on Cardio-

Aug. 1 - vascular Preventive Medicine for Primary Care Physicians, Conner Prairie Settlement, Noblesville.

July 24-26 - Psychodrama Workshop: Terminating Relationships, Action Methods Training Center, Carmel.

Aug. 12 - Practice Management Seminar: The Business Side of Medicine, presented by Nasser, Smith and Pinkerton Cardiology, Ritz Charles, Carmel.

Sept. 25-27 - Psychodrama Workshop: Psychodramatic Role Training, Action Methods Training Center, Carmel.

Oct. 2 - Arthur B. Richter Lectureship in Clinical Cardiology, Westin Hotel, Indianapolis.

For more information, call Beth Hartauer, (317) 871-3460.

Methodist Hospital of Indiana Methodist Hospital of Indiana will sponsor these CME courses:

July 17 - Neonatal and Pediatric Ultrasound.

Aug. 13-14 - Ultrasound Physics.

Sept. 12 - Selected Topics in Ultrasound.

Oct. 1-2 - Ochsner Lecture - Head & Neck Imaging.

All conferences will be held in the Main Radiology Classroom at

Methodist Hospital in Indianapolis. For more information, call Gonzalo Chua, M.D., (317) 929-8210.

Indiana University

The Indiana University School of Medicine will sponsor these courses:

July 31- - Laparoscopy and Its Complications, University Place Conference Center, Indianapolis.

Sept. 19 - Glaucoma Update, University Place Conference Center, Indianapolis.

Sept. 21-23 - Clinical Application of Echocardiographic Techniques, co-sponsored by American College of Cardiology, University Place Conference Center, Indianapolis.

Sept. 25-26 - Cardiology for Internal Medicine, Krannert Institute, Indianapolis.

Sept. 28-30 - Neonatal Nutrition Conference, University Place Conference Center, Indianapolis.

Oct. 1 - Gastroenterology Update, University Place Conference Center, Indianapolis.

For more information, call (317) 274-8353.

Union Hospital - Terre Haute

Union Hospital will sponsor the Fourth Annual Cardiovascular Symposium Sept. 19 at the Holiday Inn in Terre Haute.

Kenneth H. Cooper, M.D., chairman of the Cooper Clinic in Dallas, will be the guest speaker.

For details, call Brenda Fischer at (812) 238-7306.

Community Hospitals

Community Hospitals Indianapolis will sponsor the Third Annual Cardiovascular Symposium: Management Strategies for Primary Care Practitioners Sept. 19 at the Radisson Plaza Hotel in Indianapolis. For more information, call Donna Grahn, (317) 355-5714.

Indpls. Regional Heart Center

The Indianapolis Regional Heart Center will sponsor these courses:

Aug. 20 - CCU Office-Based Cardiology Refresher Course.

Sept. 1 - Cardiology Grand Rounds, Holiday Inn, Shelbyville.

Sept. 15 - Practice Management for Family Practice Residents.

Sept. 17 - CCU Office-Based Cardiology Refresher Course.

All conferences except the Sept. 1 listing will be held at the Indianapolis Regional Heart Center at St. Francis Hospital in Indianapolis. For details, call Marsha Breen, (317) 783-2776.

St. Mary's Medical Center

St. Mary's Medical Center in Evansville will sponsor these CME courses:

Sept. 10 - The Joseph E. Coleman Pediatric Seminar, Fevers and Immunizations, St. Mary's Medical Center Amphitheatre, Evansville.

Sept. 17 - The Oncology Seminar, The Chess Game of Cancer, Tri-State Hematology Oncology Consultants, Evansville.

For more information on these courses, call (812) 479-4468. □

Methodist Hospital sponsors Women in Medicine day

Two authorities in women's health care will speak at the Women in Medicine program sponsored by Methodist Hospital of Indiana. The program will be from noon to 8 p.m. Wednesday, Sept. 2, at the Hyatt Regency Hotel in downtown Indianapolis.

The speakers, Margaret Jensvold, M.D., and John M. Smith, M.D., will focus on the poor quality of women's health care. Dr. Jensvold is the director of the Institute on Women's Health Research at the National Institutes of Health. She is also a private practitioner specializing in adult psychiatry, women's health

and clinical psychopharmacology. Dr. Smith is the author of *Women and Doctors*, a physician's account of women's medical treatment and mistreatment in America.

For more information on the program or to register, call the Office of Physician Relations at Methodist Hospital, (317) 929-2444.

Endowment honors Fort Wayne physician

In honor of the late Samuel Motanya, M.D., a memorial endowment to benefit Three Rivers Health Services in Fort Wayne has been established. Dr. Motanya was an obstetrician/gynecologist who volunteered at the non-profit,

prenatal care clinic when he began practicing in Fort Wayne seven years ago. He died in October 1991.

Contributions may be sent to Motanya Memorial Endowment, c/o Three Rivers Health Services, 1001 Fulton St., Fort Wayne, IN 46802-2909.

IU researchers focus on transplant therapy

In search of new therapies for blood-related congenital disorders, hematologists and oncologists at the Indiana University Medical Center in Indianapolis and the VA Medical Center in Reno, Nev., have taken the first step toward developing a transplant therapy to treat diseases that can be diagnosed during the first trimester of life. They have created a xenogeneic hematologic chimera, an artificially produced organism composed of two or more genetically distinct tissues, by introducing a select group of adult human bone marrow cells into an unborn lamb.

Chief investigator Edward F. Srour, Ph.D., and his colleagues at the IUMC, Ronald Hoffman, M.D.; John Brandt, B.S.; and Nyla A. Herema, Ph.D., worked with Esmail Zanjani, Ph.D., of Reno. They transplanted a "fraction" of adult human bone marrow cells enriched with stem cells into a fetal lamb during its first trimester of development. Three months after the lamb's birth, the researchers found that approximately 6% of the lamb's bone marrow cells displayed a DNA fingerprint pattern identical to that of the human donor DNA, offering evidence of a successful transplant. □



Melinda Farris, left, president of Capitol Resources in Washington, D.C., conducted the Indiana Medical Political Action Committee seminar on "Political Leadership in the '90s" for ISMA members and their spouses. Also attending the event were Michelle Johnson, program administrator for American Medical Political Action Committee (AMPAC) political education, and Jay Keese, regional political director for AMPAC. The seminar was held May 13 in Indianapolis.

■ obituaries

James L. Arrowsmith, M.D.

Dr. Arrowsmith, 73, a retired Munster urologist, died April 27.

He was a 1943 graduate of the Northwestern University Medical School.

Dr. Arrowsmith practiced in the Calumet area for 40 years and retired in 1980.

Howard E. Burg, M.D.

Dr. Burg, 46, a Newburgh internist, died March 19 at St. Mary's Medical Center in Evansville.

He was a 1972 graduate of the Northwestern University Medical School and completed his internship and residency at the Cleveland Clinic.

Dr. Burg was a member of the American Association for the Study of Headaches and the American Pain Society. He taught in the family practice residency program at St. Mary's Medical Center and Deaconess Hospital and was a clinical instructor at the Indiana University School of Medicine.

Alfred J. Dainko, M.D.

Dr. Dainko, 81, a retired Whiting physician, died March 24 at his home.

He graduated from the Medical College of Wisconsin in 1936 and was a flight surgeon in the U.S. Air Force during World War II. In 1981, he received the St. Joseph the Worker Award from the Calumet College of St. Joseph.

Dr. Dainko served on the board of directors at St. Catherine Hospital in East Chicago and practiced medicine in the area for 56 years. He was a member of the ISMA Fifty Year Club.

Marvin A. Evens, M.D.

Dr. Evens, 57, an anesthesiologist for Community Hospitals in Indianapolis, died April 11. He died after ejecting from the A-10

attack jet he was flying while performing routine training maneuvers near Grissom Air Force Base.

He was a 1968 graduate of the Indiana University School of Medicine and a pilot in the Vietnam War, where he flew 108 combat missions.

Dr. Evens was commander of the 930th Medical Squadron, part of the 930th Fighter Group based at Grissom Air Force Base. He received four medals for his military service.

Erling S. Fugelso, M.D.

Dr. Fugelso, 83, a retired Bloomington internist and U.S. Army Medical Corps Colonel, died March 23 at the Medical Center in Bowling Green, Ky.

He was a 1932 graduate of the University of Nebraska College of Medicine and an Army veteran of World War II. After the war, he was stationed as a surgeon in Alaska, where he battled a tuberculosis epidemic among Indians and Eskimos.

From 1960 to 1963, he was director of health in the Panama Canal Zone. Dr. Fugelso retired from the Army in 1964. From 1967 to 1984, he treated students and trained interns at the health clinic at Indiana University.

Paul G. Iske, M.D.

Dr. Iske, 93, Indianapolis, a former president of the Indiana Heart Foundation, died April 2.

He was a 1927 graduate of the Indiana University School of Medicine and an Army veteran of World War II. He served as commanding officer at a military hospital in New Guinea and in Dutch New Guinea.

Dr. Iske practiced internal medicine 50 years in Indianapolis. He also taught at the IU School of Medicine.

Richard H. Miller, M.D.

Dr. Miller, 87, a retired surgeon, died Feb. 26 at St. Anne's Home in Fort Wayne.

He was a 1933 graduate of the Indiana University School of Medicine and a major in the Army Air Force during World War II.

Dr. Miller was on the staff of St. Joseph Medical Center for more than 50 years and was the medical director for International Harvester for 35 years. He was a fellow of the American College of Surgeons.

Lillian G. Moulton, M.D.

Dr. Moulton, 93, of Terre Haute died April 6 in Union Hospital in Terre Haute.

She was a 1922 graduate of the Tufts University School of Medicine in Massachusetts and was formerly senior physician for Danvers State Hospital.

Before retiring in 1977, Dr. Moulton was director of the Vanderburgh County Child Guidance Center. She also worked for the Indiana Department of Public Welfare, Mental Health Division, and had a private psychiatric practice.

Constantine G. Panos, M.D.

Dr. Panos, 62, a retired Bluffton family practitioner, died March 9 at the Caylor-Nickel Medical Center in Bluffton.

He was a 1956 graduate of the Pritzker School of Medicine at the University of Chicago.

Dr. Panos, who was certified by the American Board of Family Practice, had practiced in Bluffton since 1958. In 1972, he became associated with Caylor-Nickel as head of the general practice section. He was coordinator and a volunteer at the Bluffton Free Clinic and a member of Citizens Against Drug Abuse of Wells

County and the Governor's Task Force for a Drug-Free Indiana.

John D. Pattison, M.D.

Dr. Pattison, 72, a retired Marion internist, died Feb. 25 at Lutheran Hospital in Fort Wayne.

He was a 1944 graduate of the University of Pittsburgh School of Medicine. He served with the Navy during World War II and as a flight surgeon during the Korean War.

Dr. Pattison was an internist in Marion from 1955 until 1991, when he retired. He served two terms as Grant County coroner.

Richard C. Powell, M.D.

Dr. Powell, 62, an Indianapolis endocrinologist, died April 17.

He was a 1955 graduate of the Northwestern University School of Medicine.

Dr. Powell was a professor of medicine, biochemistry and molecular biology at the Indiana University School of Medicine and associate chairman of graduate education. He received the 1978 Distinguished Teaching Award from Indiana University and the Golden Apple Award for outstanding teaching from the university medical students. He was a fellow and past governor from

Indiana in the American College of Physicians.

Norman F. Richard, M.D.

Dr. Richard, 80, a retired Shelbyville surgeon, died March 15.

He was a 1938 graduate of the Indiana University School of Medicine and served as an Army surgeon during World War II.

Dr. Richard had a general surgery practice in Shelbyville from 1940 to 1970 and later practiced in Angola for 10 years. He was Steuben County coroner from 1972 to 1980 and Shelby County coroner from 1985 to 1990. In 1969, he was named Outstanding Citizen of Shelby County by the Chamber of Commerce.

John C. Shattuck, M.D.

Dr. Shattuck, 86, a retired Brazil, Ind., family practitioner, died April 3 in the Clay County Health Center.

He was a 1929 graduate of the Indiana University School of Medicine.

Dr. Shattuck lived in Brazil his entire life. He was named a Sagamore of the Wabash by former Gov. George N. Craig.

William L. Wissman, M.D.

Dr. Wissman, 76, formerly of Columbus, Ind., died April 29 in Naples, Fla. He had been a general practitioner and anesthesiologist in Columbus.

He was a 1941 graduate of the Indiana University School of Medicine. He served in the Army Medical Corps during World War II and received the Bronze Star for service in the Philippines.

Dr. Wissman had been president of the Bartholomew County Medical Society and chief of staff at Bartholomew County Hospital.

John M. Young, M.D.

Dr. Young, 82, a retired Indianapolis urologist, died March 19 in his home.

He was a 1934 graduate of the Indiana University School of Medicine and served as a medical officer with the Army Air Forces during World War II.

Dr. Young was an assistant professor of urology at the IU School of Medicine and had a private practice in urology until he retired in 1973. He was a fellow of the American College of Surgeons, a diplomate of the American Board of Urology and a member of the American Urological Association. □



Dr. Surawicz

Dr. Borys Surawicz, a cardiologist with Nasser, Smith and Pinkerton Cardiology in Indianapolis, received the 1992 Distinguished

Scientist Award from the North American Society of Pacing and Electrophysiology. The award acknowledges the contributions of those whose efforts have made an important impact upon the health of the nation and world.

Dr. Richard W. Campbell, director of internal medicine at Methodist Hospital in Indianapolis, was elected governor of the Indiana Chapter of the American College of Physicians.

Dr. Fred W. Dahling, a New Haven family practitioner and past ISMA president, gave a presentation on "Current Concepts in Geriatric Clinical Laboratory Tests" at the annual meeting of the Indiana Society for Medical Technology in Fort Wayne.

Dr. James G. Buchholz of Fort Wayne was elected to the board of directors of the American Academy of Orthopaedic Surgeons.

Dr. Patsy S. Maikranz, an Indianapolis critical care medicine specialist, is included in the 1992 edition of *Who's Who Among Rising Young Americans*.

Dr. Robert J. Alonso, an Indianapolis neurologist, was elected a fellow of the American College of Physicians.

Dr. Randolph W. Lievertz of Indianapolis was elected chairman of the Department of Family Practice at Midwest Medical Center and was appointed associate professor in the Department of Primary Health Care Nursing at In-

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

March

Arnbjarnarson, Oskar, Indianapolis
Fawver, Jay D., Fort Wayne
Gibson, Floyd B., Carmel
Kamen, Jack M., Indianapolis
Penn, Robert A., Lake Station
Pletzer, Arden C., Anderson
Renkens, Kenneth L., Indianapolis
Robison, Roger F., Vincennes
Shah, Rekha B., Munster
Trusler, Harold M., Indianapolis
Tuason, Leonorio B., Martinsville

April

Adler, Alan J., Kokomo
Artis, Myrle E., Kokomo
Atkins, Clayton H., Greenwood
Baker, Eldon E., Delphi
Benedict, Harold G., Anderson
Blusys, Paulius V., Leo
Brogan, Thomas M., Indianapolis
Clark, Diana L., Greenwood
Clutter, Robert E., Indianapolis
Cockrell, Dale K., Plainfield
Fields, Max L., Monticello
Gomez, Cesar M., Hammond
Green, Robert F., Corunna
Hassan, Zahia M., Evansville
Hehemann, William V., Munster

Hodonos, Phillip E., Michigan City
Jones, Thomas A., Indianapolis
Judge, Robert E., Berne
Kammeyer, William A., Fort Wayne
Lievertz, Randolph W., Indianapolis
Lloyd-Jones, Trevor T., New Palestine
Lucas, Owen H., Chesterton
Maestro, Calvin J., Munster
Markham, Raymond E., Indianapolis
McCoy, Melvin H., Evansville
Mohrman, Michael S., Fort Wayne
Morton, Philip M., Indianapolis
Mourtada, Raghid, Fort Wayne
Pancner, Ronald J., Fort Wayne
Perkins, Stephen W., Indianapolis
Peterson, John C., Muncie
Powers, William R., Lyons
Ragsdale, Rex H., Evansville
Rahdert, Richard F., West Lafayette
Rains, Daniel P., New Castle
Scherschel, Kim P., Bedford
Sharp, Gary C., Greenfield
Sidell, James P., New Haven
Streepey, Janet L., Munster
Summers, Michael L., Greenfield
Weinbaum, Marc, Anderson
Wesemann, Merrill M., Franklin
Zent, Don P., Kokomo

diana University in Indianapolis. He was recently selected by the American Society for Clinical Pharmacology and Therapeutics to be a reviewer for papers submitted to the neuropsychopharmacology section for presentation at next year's meeting.

Dr. Richard D. Zeph, a Carmel facial plastic surgeon, spoke on microtia repair and auricular reconstruction at the 1992 Midwestern Region Meeting of the American Academy of Facial Plastic and Reconstructive Surgery; he also was a panelist on difficult cases in aesthetic facial rejuvenation. He discussed the

following topics at the Indianapolis Facial Plastic Surgery Seminar sponsored by the Indiana University School of Medicine: chin augmentation and the genioman-dibular groove, external ear reconstruction, pearls and adjuncts to facial rejuvenation and skeletal augmentation and profileplasty.

Dr. C. Dyke Egnatz, ISMA president and a Schererville family practitioner, is a member of the executive golf committee for the Tradewinds Golf Classic, which will be held July 27 to benefit Project Link, Linking Infants in Need of Kare.

Activities and accomplish-

ments of physicians from Orthopaedics Indianapolis include the following: **Dr. D. Kevin Scheid** is the editor of *Orthopaedic Trauma Update*, a new quarterly newsletter being distributed statewide. **Dr. David A. Fischer** discussed "Strain in the Cement Mantle of Femoral Prosthesis" and "Cost Containment in Hip Arthroplasty" at the Orthopaedic Implant Technology meeting in Breckenridge, Colo., and presented a paper on "Autologous Blood Use in Total Joint Replacement" at the Mid-America Orthopaedic Association meeting in Orlando, Fla. **Dr. Sanford S. Kunkel** is the author of an article on "Rotator Cuff Repair in the Athlete" in a book titled *The Athlete's Shoulder*. **Dr. Dean C. Maar** co-authored presentations on "Surgical Decompression for Perineal Nerve Palsy Complicating Total Knee Arthroplasty," "Cemented vs. Uncemented Primary Total Knee Arthroplasty" and "Ipsilateral Femur Fractures Complicating Hip Arthroplasty." **Dr. F. Robert Brueckmann** discussed "Flexible Intramedullary Nailing - Advanced Techniques" and **Dr. Terry R. Trammel** spoke on "The Comparison of Harrington Distraction Instrumentation to CD Instrumentation in the Treatment of Fractures of the Thoracolumbar Spine" at the annual meeting of the American Academy of Orthopaedic Surgeons meeting in Washington, D.C. The following physicians gave presentations at the meeting of the Indiana Orthopaedic Society in Columbus, Ind.: **Dr. Michael F. Coscia**, "The A.O. Internal Fixator for Treatment of Thoracolumbar Spinal Fractures" and "Use of Rogozinski Instrumentation in Lumbar Spinal Fusion"; **Dr. Sanford S. Kunkel**, "ACL Reconstruction - Current

Concepts"; and **Dr. Joseph C. Randolph**, "The Results of PCL Repair in a Large Metropolitan Community."

Dr. J. Douglas Graham of the Indianapolis Regional Heart Center presented findings from the Children's Heart Health Research Project during the Great Lakes Hypertension Conference.

Dr. Bruce F. Waller of Nasser, Smith and Pinkerton Cardiology in Indianapolis, addressed the International Convention for Advances in Atherosclerotic Heart Disease in Tubingen, Germany; his presentation was titled "Histologic Relevant Techniques for Induction of Smooth Muscle Cell Proliferation." He gave a program on "Anatomic Causes of Congestive Heart Failure" at the Osteopathic Physicians and Surgeons convention in Indianapolis and spoke on "Thrombolytics and Anti-Coagulation in the Interventional Era" at the American College of Cardiology symposium in Dallas.

Activities and accomplishments of physicians at the Indiana Hand Center in Indianapolis include the following: **Dr. James W. Strickland** was elected to the board of directors of the American Academy of Orthopaedic Surgeons. **Dr. Hill Hastings II** was a faculty member and lab coordinator and **Dr. Thomas J. Fischer** was a faculty member and associate lab coordinator at the AO/ASIF Hand Course in San Diego. Dr. Hastings gave a presentation on "Evaluation and Management of Proximal Interphalangeal Joint Fractures" at a meeting of the American Society for Surgery of the Hand. Dr. Fischer spoke on endoscopic carpal tunnel release at the Maine Academy of Orthopaedic Surgery winter meeting in Sugarloaf, Maine.

Dr. Vidyasagar S. Tumuluri

of Beech Grove has changed the name of his professional corporation to South Indy Hand Center.

Dr. Eugene Klatte of Indianapolis was honored with the establishment of a \$1 million endowed chair in his name at the Indiana University Medical Center; he recently retired as chairman of the Department of Radiology but will continue teaching and working in pediatric radiology.

Dr. Eric L. DeWeese, Danville, and **Dr. Frederick Tolle**, Indianapolis, both of Pulmonary Associates, have passed board exams in critical care medicine.

Dr. George K. Brodell of the Arnett Clinic in Lafayette was elected to fellowship in the American College of Cardiology.

Dr. Daniel J. Combs, a Vincennes internist, was named Physician of the Year by the Indiana Medical Review Organization.

Dr. Patricia A. Keener, chief of pediatrics at Wishard Memorial Hospital in Indianapolis and medical adviser to the Indianapolis Campaign for Healthy Babies, received the Matrix Award from the Indianapolis professional chapter of Women in Communications; the award is given to someone with close ties to Indiana whose professional influence and accomplishments are national in scope.

Dr. Randall A. Lee, a Martinsville internist, was elected to fellowship in the American College of Physicians.

Dr. Thomas J. Lord, an Indianapolis cardiologist, and his family were named the United States Tennis Association's 1991 Family of the Year. Dr. Lord has been a consulting physician for the Virginia Slims of Indianapolis event and assisted at the U.S. Clay Courts and GIE Hard Court Championships.

■ people

Indianapolis physicians **Dr. Deborah S. Provisor**, a pediatric hematologist/oncologist; **Dr. Chace Lottich**, a general surgeon; **Dr. Stephen M. Schultz**, a hematologist; and **Dr. Virginia M. Wagner**, a pediatrician, were elected to the board of directors of the Little Red Door Cancer Agency.

Dr. Louie O. Dayson, director of cardiology at Good Samaritan Hospital in Vincennes, received the Walter A. Davis Memorial Citation for service from Vincennes University; the award is presented annually by the VU Alumni Association in recognition of outstanding humanitarian service to the community.

Dr. Robert E. Swint Sr., a Fort Wayne cardiologist, was recognized as one of the "15 Who Care" by the Volunteer Connection; he was recognized for his many volunteer efforts, including the Matthew 25 Health and Dental Clinic, Senior Health Care Coordinating Council and Three Rivers Health Clinic.

Dr. Bennie F. Carpenter, a Crown Point family practitioner, was named president of the medical staff at St. Anthony Medical Center.

Dr. Stephen J. Burns of Michigan City, **Dr. R. Kent Moseman** of Bloomington, **Dr. John G. Peters** of Beech Grove and **Dr. Terry D. Fenwick** of Vincennes were inducted as fellows of the American Academy of Orthopaedic Surgeons.

Dr. Max R. Long has retired after 46 years as a Marion family practitioner. □

New ISMA members

George F. Abu-Aita, M.D., Merrillville, neurology.

Tiruvury Anuradha, M.D.,

Chicago, pediatrics.

David L. Ashbach, M.D., Munster, nephrology.

Theodore M. Bailey III, M.D., Indianapolis, anatomic pathology.

Richard L. Cristea, M.D., Merrillville, neurology.

Bryan G. Cunningham, M.D., Huber Heights, Ohio, anatomic/clinical pathology.

Robert A. De Weese, M.D., Columbus, radiology.

Martin L. Engman, M.D., Fort Wayne, internal medicine.

Blaine W. Farley, M.D., Carmel, emergency medicine.

Stephen H. Garry, M.D., Indianapolis, emergency medicine.

William E. Gist, M.D., Anderson, obstetrics and gynecology.

Glenn L. Goldstein, M.D., Fort Wayne, colon and rectal surgery.

David J. Gorecki, M.D., LaPorte, cardiovascular diseases.

James H. Greenwald, M.D., Munster, nephrology.

Nabil Haffar, M.D., Munster, obstetrics and gynecology.

Louis A. Hahn, M.D., Kokomo, emergency medicine.

Donald R. Hawes, M.D., Indianapolis, diagnostic radiology.

Alan H. Hendrix, M.D., Vincennes, anesthesiology.

Dennis M. Jacob, M.D., Indianapolis, vascular surgery.

Ellen M. Jansyn, M.D., Blue Island, Ill., internal medicine.

John A. Knudson, M.D., Beech Grove, vascular surgery.

Thanomsakdi Kullavanijaya, M.D., Crown Point, anesthesiology.

Eric D. Ladenheim, M.D., Fort Wayne, general surgery.

Melinda A. Liller, M.D., Crown Point, diagnostic radiology.

Walter B. Lindsey, M.D., Gary, family practice.

Rolf C. Loescher, M.D., Columbus, obstetrics and gynecol-

ogy.

Gregory J. Loomis, M.D., Evansville, neurological surgery.

John F. Maesaka, M.D., Fort Wayne, radiology.

Garry B. Malnar, D.O., Valparaiso, diagnostic radiology.

Bharat V. Merai, M.D., Schererville, anesthesiology.

David C. Merz, M.D., Munster, internal medicine.

Steven F. Mischel, D.O., Munster, nephrology.

Daniel J. Motyka, D.O., Crown Point, emergency medicine.

Patrick W. Russell, D.O., Elkhart, neurology.

Marguerite A. Saith, M.D., Anderson, internal medicine.

Sharma Saith, M.D., Anderson, cardiovascular diseases.

Jonathan L. Schmidt, M.D., Muncie, otolaryngology.

Kevin P. Short, M.D., Muncie, thoracic surgery.

Larry H. Stevens, M.D., Indianapolis, general surgery.

Habib Tagizadieh, M.D., Hammond, orthopaedic surgery.

Franky E. Voss, M.D., Muncie, obstetrics and gynecology.

Donald M. Wardell III, M.D., New Castle, internal medicine.

Daniel R. Whipple, M.D., Danville, ophthalmology.

Choong J. Yoon, M.D., Merrillville, physical medicine and rehabilitation.

Residents

Lori L. Davidson, M.D., Indianapolis, obstetrics and gynecology.

Gregory T. Hardin, M.D., Indianapolis, orthopaedic surgery.

Donald J. McIntire, M.D., Indianapolis, pediatrics.

Jeffery L. Pierson, M.D., Indianapolis, orthopaedic surgery.

Kevin A. Wurst, M.D., New Albany, emergency medicine. □

PHYSICIAN PRACTICE OPPORTUNITIES - Statewide/nationwide/worldwide. All specialties, group/solo, varied income arrangements. Contact Larson & Trent Associates, Box 1, Sumner, IL 62466-0001. Telephone: (618) 936-2662, 936-2970 or 1-800-352-6226.

SOLO PEDIATRICS with coverage available. Kokomo is an excellent place to practice, having two fine hospitals, strong community spirit, four-year university and a solid industrial base. D.L. Fields, M.D., P.O. Box 2705, Kokomo, IN 46902.

WOMEN'S CENTER seeking BC OBG. Hospital-sponsored center in Chicago's western suburbs features OBG, internal medicine, dermatology, psychology, mammography, therapeutic massage and community health education programs in a 6,000-square-foot facility. Guaranteed salary/productivity/relocation expenses. Contact Ms. Mariko Blouin, Healthcare Management Associates, 980 N. Michigan Ave., Suite 1520, Chicago, IL 60611, (312) 951-2929 or 1-800-441-2930 or fax CV anytime to (312) 951-6680.

MULTI-SPECIALTY GROUP seeking BC OBG. Located in resort and beach area. 55 miles from Chicago. New OB office setting, excellent income guarantee and benefit package. Contact Ms. Mariko Blouin, Healthcare Management Associates, 980 N. Michigan Ave., Suite 1520, Chicago, IL 60611, (312) 951-2929 or 1-800-441-2930 or fax CV anytime to (312) 951-6680.

PARTNERSHIP OPPORTUNITY for BC family physician or internist. Growing private/industrial practice. No OB. Guaranteed salary/productivity/relocation expenses. Contact Ms. Mariko Blouin, Healthcare Management Associates, 980 N. Michigan Ave., Suite 1520, Chicago, IL 60611, (312) 951-2929 or 1-800-441-2930 or fax CV anytime to (312) 951-6680.

FAMILY HEALTH CENTER seeks family physician to provide OB and primary care services in hospital-based center. Base salary + inpatient billing revenues. Contact Ms. Mariko Blouin, Healthcare Management Associates, 980 N. Michigan Ave., Suite 1520, Chicago, IL 60611, (312) 951-2929 or 1-800-441-2930 or fax CV anytime to (312) 951-6680.

OPPORTUNITY FOR SOLO/GROUP family physician or internist to start second office or relocate office to Chicago's Lincoln Park. Various incentives and income guarantees. Contact Ms. Mariko Blouin, Healthcare Management Associates, 980 N. Michigan Ave., Suite 1520, Chicago, IL 60611, (312) 951-2929 or 1-800-441-2930 or fax CV anytime to (312) 951-6680.

EMERGENCY MEDICINE - Part-time positions available for medium-volume emergency department. Offering flexible scheduling, competitive wages and malpractice insurance coverage. Prefer BC/BE in FP or emergency medicine. Contact Jeff Kennedy at 1-800-676-5572, Dearborn County Hospital, Lawrenceburg, Ind.

OHIO-WISCONSIN-MICHIGAN-MISSOURI: Attractive opportunities in metropolitan and scenic recreational areas. Locations near pristine lakes, white water rivers and national forests. Others in college communities offering professional and Big 10 college sports, fine arts and a broad spectrum of nationally renowned CME programs. Positions available: allergy, dermatology, neurosurgery, occupational medicine, oncology, orthopaedics, psychiatry, rheumatology and urology. To discuss your practice preferences and these opportunities, please call our toll-free number, 1-800-243-4353, or send your CV to STRELCHECK & ASSOCIATES, INC., 10624 N. Port Washington Road, Mequon, WI 53092.

INTERNAL MEDICINE, FAMILY PRACTICE, URGENT CARE, OB/GYN AND ACADEMICS: Positions in large metropolitan cities, urban and rural communities with a concentration in the Great Lakes area and Plains states. Whether you prefer a cosmopolitan lifestyle, a city surrounded by nature and the beauty of the four seasons, the peaceful rolling farm country or perhaps life in historic villages, there is something for everyone. To discuss your practice preferences and these opportunities, please call our toll-free number, 1-800-243-4353, or send your CV to STRELCHECK & ASSOCIATES, INC., 10624 N. Port Washington Road, Mequon, WI 53092.

PSYCHIATRIST - Full- and part-time openings now available at Central State Hospital in Indianapolis. Competitive salary, state employment benefits, flexible hours. Challenging assignments in direct patient care. Call medical director, James Donahue, M.D., (317) 639-3636.

GOSHEN, IND - Internist. Locum tenens for occasional weekend. Friday noon through Monday morning. Hospital critical care ICU/CCU call/coverage. Housing transportation provided. For further information, call 1-800-258-4321 ext. 2610.

NEPHROLOGY FELLOW - Position available for first-year fellow at Methodist Hospital of Indiana Graduate Medical Center. Methodist Hospital has 1,000 inpatient beds and over 40,000 admissions per year. There is a busy 12-bed hemodialysis unit as well as a 40-bed renal patient unit. There are 80 critical care beds in the hospital, with dedicated neurosurgical, medical, cardiovascular and coronary care units. Methodist is a state-of-the-art facility featuring 33 surgical suites, 5 cardiac catheterization laboratories, 2 hyperbaric chambers and 2 renal laboratories as well as 2 MRI and 6 CT units.

■classifieds

ners. The hospital is JCAHO-accredited, and all residency and fellowship programs, including family practice, internal medicine, general surgery, ob/gyn, pediatrics, cardiology/pulmonary & nephrology are ACGME-accredited. A strong tradition of graduate medical education since 1908 with competitive salary/benefits package. Excellent board-certified nephrology faculty offering expertise and clinical instruction/experiences in managing acute and chronic renal failure, hemodialysis, peritoneal dialysis, transplantation, metabolic stone disease, critical care, as well as extensive outpatient dialysis exposure. Clinical research opportunities available. For more information, please contact Kristi Osborn, Department of Academic Affairs, Methodist Hospital of Indiana, 1701 N. Senate Blvd., P.O. Box 1367, Indianapolis, IN 46206, (317) 929-8015.

PRACTICE TRIALS-LOCUM TENENS-PERMANENT PLACEMENT - Primary care physicians. You know all the benefits of locum tenens medicine. Join the one company that specializes in primary care. We put together "temporary solutions" and "lasting relationships." Great income, reasonable hours and travel opportunities. Call INTERIM PHYSICIANS at 1-800-925-2144.

RADIOLOGY - Seven-person group is seeking an eighth radiologist with special interest in cross-sectional imaging. The Department of Radiology is expanding, is well-staffed and has all new and modern equipment. The initial salary is competitive, with a guaranteed bonus. The all-inclusive benefits are generous, with partnership potential. The excellent practice opportunity offers suburban living at its best and is located 45 minutes from downtown Chicago. For further information, please contact Peter E. Doris, M.D., Chairman, or Antogni Kencos, M.D., Vice Chairman, Department of Radiology, St.

Anthony Medical Center, Crown Point, IN 46307, (219) 757-6320.

PRACTICE FOR SALE: Large family practice available in east central Indiana urban area. Excellent full-service hospital facility located in the area. Fine environment for living and raising family. Gross income of the practice averaged \$450,000 in last three years. Will remain to introduce and assist in the transition. For further details, write to P.O. Box 0983, Indianapolis, IN 46206-0983.

FAMILY PRACTICE opportunities available in Fort Wayne, Ind. Practice setting extremely flexible. Solo or group. Salary guarantee, relocation and other expenses paid. An opportunity to practice medicine and leave administrative and billing headaches to someone else. For complete details, contact our physician recruiting officer at (219) 489-2772, ext. 415.

PRIMARY CARE PHYSICIAN - Wanted for ambulatory care center. Paid malpractice. Flexible hours. \$80,000-\$120,000 plus incentive bonus depending on hours, training and experience. Indianapolis location. Phone (317) 861-5637.

URGENT CARE - FT or PT opportunities available in busy, well established Cedar Rapids urgent care center. Occupational medicine, including pre-employment evaluations and work-related injury treatment, is also part of the practice. X-ray, laboratory and physical therapy services available within clinic. Cedar Rapids, population 110,000, is located in eastern Iowa and is 30 minutes from the University of Iowa. Excellent compensation and scheduled hours. Mail CV or call Bob Waste, Mercy Care Management, P.O. Box 786, Cedar Rapids, IA, 52406, (319) 398-6460.

EMERGENCY CARE PHYSICIANS - Expanding emergency services medical group seeking career-

mind physicians for multiple Indiana locations. 20-year history without a lost contract. Hourly compensation based on training, experience and qualifications. Excellent benefits including life/health/disability and malpractice insurance plus CME allowance/ACEP and ISMA dues/and pension. Will consider all physicians with emergency medicine experience and interests. Contact Jim Gardner, M.D., corporate development, or Steve Augustine, physician relations, Emergency Care Physicians, 640 S. Walker St., Suite A, Bloomington, IN 47403, (812) 333-2731.

EMERGENCY MEDICINE - Our high-quality, low-key emergency medicine group is looking for a BC/BE or well-experienced emergency physician to join our practice at a 29,000-volume E.D. We are a fee-for-service group with good income and benefits. Full salary attained in only one year. Lafayette is a safe and pleasant college town, allowing for a high quality of living. Contact Lance Seagren or John Woods at (317) 447-4517, 1308 Lockwood Dr., Lafayette, IN 47905.

DOOR COUNTY, WISCONSIN - BC/BE internist. Modern, 89-bed community hospital with new outpatient services addition. Competitive guaranteed salary. Incentive package. Malpractice insurance. Attractive benefits. Exceptional four seasons recreation along Lake Michigan shores. Proximity to Milwaukee/Chicago. Top-rated schools. Quality community life. Send CV to Priscilla Khoury, Physician Recruitment Coordinator, 330 S. 16th Place, Sturgeon Bay, WI 54235.

DOOR COUNTY, WISCONSIN - Emergency medicine. BC/BE family practice, internal medicine, pediatrics or emergency medicine. General emergency medicine experience required. ACLS/ATLS required, PALS preferred. Full-time

position with 8-10 24-hour shifts monthly with flexibility. Competitive salary and benefits package. Modern 89-bed hospital with a new emergency department and outpatient services addition. Approximately 10,000 visits per year. Exceptional four seasons recreation along Lake Michigan shores. Proximity to Milwaukee/Chicago. Top-rated schools. Quality community life. Send CV to Priscilla Khoury, Physician Recruitment Coordinator, 330 S. 16th Place, Sturgeon Bay, WI 54235.

IMMEDIATE CARE PHYSICIANS - Expanding immediate care Indianapolis-based group seeks career-minded primary physicians for multiple clinical locations. Ten-year profitable history second to none in the metropolitan Indianapolis area. Physician-owned and operated. Corporation. Compensation based on training, experience and qualifications. Excellent benefits including life/health/disability and malpractice insurance plus CME allowance/state and local dues and pension. Will consider all primary medical disciplines with interest in outpatient medicine. All candidates selected for F/T opportunities only. Contact Steven K. Augustine, Director, Physician Relations, Immediate Care Centers, c/o 640 S. Walker St., Suite A, Bloomington, IN 47403, (812) 333-

2731.

HEMATOLOGY-ONCOLOGY: Private practice in southwest Indiana looking for associate leading to partnership. Extensive referral listings and excellent health care facilities. Respond to Tri-State Hematology Oncology, P.O. Box 5069, Evansville, IN 47716-5069.

FAMILY PRACTITIONERS/INTERNISTS - MetroHealth, an affiliate of Methodist Hospital of Indiana, Inc., is seeking board-certified/eligible family practitioners and internists. Share the advantages of joining an established prepaid multi-specialty physician group offering an ideal blend of practice and lifestyle, paid professional liability and competitive compensation and fringe benefit packages. Our practice is located in Indianapolis, a thriving Midwest community offering a number of cultural, educational and recreational activities. For confidential consideration, submit curriculum vitae to MetroHealth Physician Recruitment, P.O. Box 1367, Indianapolis, IN 46206.

MULTIPLE AND VARIED physician practice opportunities currently exist both within and outside Indiana. Call Patti Quiring at work, (317) 841-7575, or at home, (317) 823-4746. Patti is a physician re-

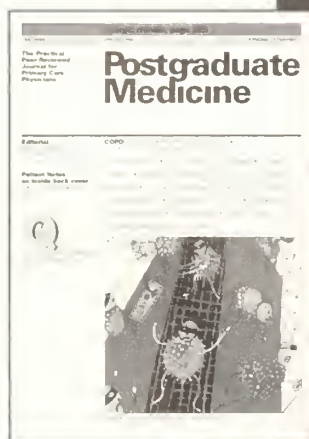
cruiter for Quiring Associates, an executive search firm headquartered in Indianapolis.

GENERAL INTERNIST - BC/BE. To join a busy five-man practice with special interest in hospital intensive care, plus consultative and primary care practice in the Indianapolis area. Will offer partnership. Reply to Box 19616, Indianapolis, IN 46219.

EMERGENCY MEDICINE - Terre Haute, Ind. Local multi-hospital group seeking full-time career-oriented emergency physician for position in small- and medium-volume community hospitals. Flexible scheduling, very competitive compensation package, partnerships available. Send CV or contact William R. Grannen, Priority Health Care, P.C., 7179 Lamplite Ct., Cincinnati, OH 45244, (513) 231-0922.

CENTRAL INDIANA - Physician-owned emergency group accepting applications for full-time career-oriented emergency physicians. Flexible work schedules and excellent benefit package. Part-time and directorship positions also available. Send CV or contact Midwest Medical Management Inc., 3645 S. East St., Indianapolis, IN 46227-1240, (317) 783-7474. J

US THEM



**Postgraduate
Medicine**

**WHEN YOU NEED
TIME ON YOUR
SIDE, THE CHOICE
IS CLEAR.**

**NO CLINICAL
CLUTTER—
PGM ARTICLES
ARE CLEAR,
CONCISE, WELL
ILLUSTRATED,
AND PRACTICAL.**

Advertising index

Affiliated Physicians Services	Cover
American Medical Association	306
American Medical Services	307
Arnett Clinic	292
Auto Buyers Network	347
Butterworth Health System	283
Central Pharmaceuticals	286
Gregory & Appel Insurance	301
Lilly, Eli & Co.	275
Medical Accounts Group	273
Medical Protective	287
Palisades Pharmaceuticals	317
Physicians' Directory	324
Physicians Insurance Co. of Indiana	Cover
Postgraduate Medicine	358
Records Management Services	317
G.D. Searle and Company	Cover
Spectrum Emergency Care	323
Speedway Mazda	272
University Place	277
U.S. Air Force	307
U.S. Army	323
U.S. Army Reserve	347

In accepting advertising for publication, INDIANA MEDICINE has exercised reasonable precaution to ensure that only reputable, factual advertisements are included. However, we do not have facilities to make comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services, medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertisers only. Neither sanction nor endorsement of such is warranted, stated or implied by the association.

Are you moving?

If so, please send change of address to the Indiana State Medical Association, Membership Department, 322 Canal Walk, Indianapolis, IN 46202-3252, at least six weeks before you move.

Name: _____
 Address: _____
 City: _____
 State: _____ Zip: _____ County: _____
 Office phone: _____ Home phone: _____

IMPORTANT - Attach mailing label from your last copy of INDIANA MEDICINE here:

ISMA Health/Dental Insurance

Benefits available to members of the Indiana State Medical Association and their employees through expanded ISMA group sponsored health insurance.

MEDICAL PLAN A

- 365 Days of Inpatient Hospital Care
- 100% payment semi-private or hospital ward room
- 365 Days In-Hospital Medical Care
- 100% reasonable and customary allowances for surgery, maternity, general anesthesia, medical visits, radiation therapy, and other eligible inpatient hospital charges
- \$2,000,000 Major Medical Benefits (\$100 deductible)

MEDICAL PLAN B

- Comprehensive Major Medical protection
- \$250 calendar year deductible, \$500 per family
- Stop-Loss Limit \$5,000 per person, \$10,000 per family
- PCS Card
- Includes cost-containment features
- \$2,000,000 Maximum Benefits

MEDICAL PLAN C

- Comprehensive Major Medical protection
- \$500 calendar year deductible, \$1,000 per family
- Stop-Loss Limit \$5,000 per person, \$10,000 per family
- \$2,000,000 Maximum Benefits

MEDICAL PLAN D

- Economical Comprehensive Major Medical protection
- \$1,000 calendar year deductible, \$2,000 per family
- Stop-Loss Limit \$5,000 per person, \$10,000 per family
- \$2,000,000 Maximum Benefits

MEDICAL PLAN E

- Low cost Comprehensive Major Medical protection
- \$2,000 calendar year deductible, \$6,000 per family
- Stop-Loss Limit \$10,000 per person, \$30,000 per family
- \$2,000,000 Maximum Benefits

BENEFITS FOR ORGAN OR TISSUE TRANSPLANTS

- Included with all medical plans
- Subject to normal plan deductibles and co-insurance
- Covered Transplant Procedures: This benefit covers any of the following human to human organ or tissue transplants: bone marrow; heart; heart/lung; liver; kidney; cornea
- Artery or vein transplants
- Joint replacements
- Heart valve replacements
- Implantable prosthetic lenses in connection with cataracts
- Prosthetic by-pass or replacement vessels
- Maximum Transplant Benefit: \$1,000,000 lifetime maximum per person for all transplant services

DENTAL PLAN

- Reasonable and customary allowances for necessary care and treatment for dental health - \$50 calendar year deductible, \$100 per family
- \$1,500 maximum dental benefit per person in a calendar year paid at 80%, additional major dental paid at 50%
- \$1,000 Orthodontia Benefits paid at 50% of reasonable and customary charges

MEDICAL REIMBURSEMENT PLAN

- Tax deductible to the professional corporation

Your benefit programs have been designed to provide the highest quality coverage and service at the lowest possible cost. A special claim paying unit has been established to handle only the ISMA program. Should you have questions or problems, you may speak directly to your claim processor. We look forward to serving you and encourage your review of the program and services being provided.

For more information regarding these coverages contact:

Tom Martens
Director, Health Insurance Administration
Indiana State Medical Association
322 Canal Walk
Indianapolis, Indiana 46202-3252
(317) 261-2060
800-257-ISMA
FAX (317) 261-2076

Earl W. Williams
Professional Account Representative
11595 N. Meridian St., Suite 802
Carmel, Indiana 46032
(317) 573-6520
800-421-3020
FAX (317) 573-6524

AFFILIATED PHYSICIANS SERVICES, INC.

ISMA Agency

For the many faces of mild hypertension



THE MOST WIDELY USED CALCIUM ANTAGONIST AS MONOTHERAPY FOR MILD HYPERTENSION^{1*}

- Effective 24-hour control²
- Single-agent efficacy
- Well tolerated³
- No adverse effects on total cholesterol, plasma glucose levels, renal function,* or serum electrolytes³⁻⁶



For the many faces of mild hypertension

*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

† Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡ Verapamil should be administered cautiously to patients with impaired renal function.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully

monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecostasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA627TV

Address medical inquiries to:
G.D. Searle & Co.
Medical & Scientific
Information Department
4301 Searle Parkway
Skokie, IL 60077

SEARLE

G.D. Searle & Co.
Box 5110, Chicago, IL 60680

INDIANA MEDICINE

The Journal of the Indiana State Medical Association

September/October 1992

Vol. 85, No. 5



3rd Annual Convention & Exposition
October 16-18, 1992
Indianapolis

10 Shattuck Street
Boston MA 02115

MS



Choosing PICI is an open and shut case

With PICI's track record for success in defending claims, it would be easy for us to rest on our laurels. But after all of our successes and words of gratitude from our physician policyholders, we still get defensive.

As a physician-owned company, dedicated to our insureds and their practices, we always defend against claims that have no merit. We do not settle suits to save money. In fact, we can not settle without your consent. Never have, never will.

When an insured's reputation is on the line, so is PICI's.

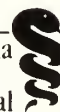
We're proud to say we're defensive. It's a way of doing business that has yielded positive results, to the relief and satisfaction of our policyholders.



**PHYSICIANS INSURANCE
COMPANY OF INDIANA**

5425 Woodfield Crossing Blvd., Suite 300
Indianapolis, IN 46240
317/469-4100 800/284-7424

Indiana
State
Medical
Association



"Together, We Make The Difference"

INDIANA MEDICINE

The Journal of the Indiana State Medical Association

September/October 1992

Vol. 85, No. 5

features

Woman physician sees need for mentors.....370

INDIANA MEDICINE interviews Doris Merritt, M.D., professor of pediatrics and associate dean of the Indiana University School of Medicine and special assistant to the president of IU, about being a woman in medicine.

Commission studies Indiana health care delivery.....378

A draft report from the State Health Policy Commission emphasizes managed care and recommends changes in the health care licensure system.

Doctor fills her life with favorite things.....382

Elizabeth Sowa, M.D., grows herbs for cooking, sews clothing and collects antique kitchen gadgets while maintaining an active practice in pediatric ophthalmology.

Women in Medicine fact sheet.....384

The AMA provides some statistics on women in medicine.

1992 Annual Convention & Exposition.....386

The 143rd annual meeting will be Oct. 16 through 18 at the Westin Hotel in downtown Indianapolis.

- ISMA annual reports.....394
- Status of 1991 resolutions.....408

Snakeroot Extract.....423

scientific contributions

Cardiac transplantation at IU Medical Center.....414

Maternal mortality in Indiana:
A report of maternal deaths in 1990.....420



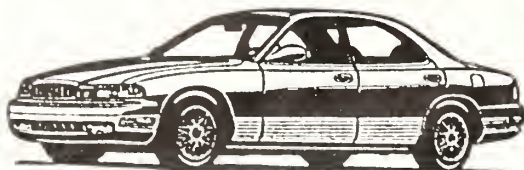
Cover story on page 386.
Cover design by Jim Bork,
Momentum Design, Indianapo-
lis.

departments

- stethoscope.....362
- editorials.....364, 366
- letter to the editor.....368
- auxiliary report.....428
- drug names.....429
- from the museum.....452
- cme calendar.....454
- news briefs.....455
- obituaries.....456
- people.....458
- correction.....461
- classifieds.....462
- isma leadership.....465

Mazda

A REVOLUTION IN LUXURY CARS. THE NEW MAZDA 929.



Mazda 929 Luxury Sedan

Revolutionary in concept,
strikingly original in execution,
the **Mazda 929** is
one luxury car that makes a
truly personal statement.

- 195-hp 24-valve V6 tuned for American driving conditions
- Roomy interior, centered around the driver
- Dual air bags - standard equipment
- Anti-lock Brake System - standard equipment
- New-generation multi-link suspension for ideal combination of ride and handling
- Special lease program

**Find out for yourself today at
Indiana's #1 Mazda Dealer
(317)263-0002**

**Speedway Mazda
1935 W. 16th St.
Indpls, IN 46202**

INDIANA MEDICINE

Devoted to the interests of the medical profession and public health in Indiana since 1908.

MANAGING EDITOR

Tina Sims

EDITORIAL ASSISTANT

Toni Settle

BUSINESS MANAGER

Richard R. King

CIRCULATION

Rosanna Iler

EDITORIAL BOARD CHAIRMAN

George T. Lukemeyer, M.D.

EDITORIAL BOARD

Thomas J. Conway, M.D.

Robert C. Ziss, M.D.

(Terms expire Dec. 31, 1992)

James R. Buechler, M.D.

James W. Edmondson, M.D.

Robert L. Forste Jr., M.D.

George C. Manning, M.D.

Bruce F. Waller, M.D.

(Terms expire Dec. 31, 1993)

Franklin Roesner

Paul Forman

(Medical students)

CONSULTING EDITORS

Steven C. Beering, M.D.

Charles A. Bonsett, M.D.

Walter J. Daly, M.D.

Alvin J. Haley, M.D.

Rodney A. Mannion, M.D.

Alan T. Marty, M.D.

EDITOR EMERITUS

Frank B. Ramsey, M.D.

INDIANA MEDICINE (ISSN 0746-8288) is published six times a year (in January, March, May, July, September and November) by the Indiana State Medical Association. Second-class postage paid at Indianapolis, Ind., and additional mailing offices.

Address correspondence relating to editorial material, advertising or subscriptions to: INDIANA MEDICINE, 322 Canal Walk, Indianapolis, IN 46202-3252. Phone (317) 261-2060 or 1-800-257-ISMA.

Annual subscription rates for nonmembers: \$15 domestic, \$17 Canada, \$18 foreign. Medical library rates: \$14 domestic, \$15 Canada, \$16 foreign. Full-time Indiana medical students: \$7. Single copies not available. Subscriptions are renewable annually.

POSTMASTER: Send address changes to INDIANA MEDICINE, Indiana State Medical Association, c/o Membership Department, 322 Canal Walk, Indianapolis, IN 46202-3252.

Views expressed do not reflect the opinions of the editors. No copyright is claimed, unless specifically indicated. Copyright rests solely with authors, who are responsible for statements in their articles. Scientific and editorial contributions are accepted for exclusive publication, subject to editorial requirements. Instructions for authors available on request.

All issues since 1967 are available on microfilm from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, MI 48106. Indexed in *Index Medicus* and *Hospital Literature Index*.

Advertising rates and data available upon request. INDIANA MEDICINE reserves the right to accept or reject advertising.

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON, MA

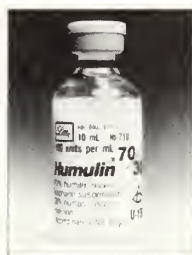
SEP 17 1992

In insulin therapy

Make life easier for many of your patients

Humulin 70/30. Convenient and simple to administer.

No more mixing. No more mixing errors.
All of which makes living with diabetes a
little easier for patients. And compliance
a lot easier to achieve.



Humulin[®] 70/30

70% human insulin isophane suspension
30% human insulin injection
(recombinant DNA origin)



Global Excellence in Diabetes Care

Eli Lilly and Company
Indianapolis, Indiana
46285

The patient-friendly premix

WARNING: Any change of insulin should be made cautiously and only
under medical supervision.

HI-7905-B-249327 ©1992, ELI LILLY AND COMPANY

Legislative subcommittee to consider changes to INCAP

The legislative Interim Study Committee on Insurance Issues has appointed a subcommittee of interested groups to recommend possible changes to the Indiana Compensation Act for Patients (INCAP), the state's malpractice law. John Render of the Indiana Hospital Association (IHA) is chairman of the five-member group, which includes representatives of the ISMA, the IHA, insurance companies and the Indiana Trial Lawyers Association. The subcommittee will study delays in the medical review panel process and the cap on malpractice awards. The deadline for the committee's recommendations was Sept. 10.

Indictment dismissed against Danville physician

The March 1990 indictment against Joseph Kerlin, M.D., Danville, for neglect of a dependent, has been dismissed by Special Prosecutor Rebecca S. McClure for insufficient evidence to support the charge.

Dr. Kerlin's position, as well as that of the ISMA and other health care providers, was that the "criminal neglect of a dependent" statute was never intended by the Indiana legislature to apply to health care providers. Dr. Kerlin, the ISMA and other health care providers continue to be concerned that if criminal liability can attach to health care providers in the exercise of their duties in nursing homes and in other health care settings, this will have a chilling effect on the willingness of health care providers to continue their involvement in the care of these patients.

State health department plans forums on cancer control

The Data-based Intervention Research Program of the Indiana State Department of Health (ISDH) is planning eight public forums on cancer control in Indiana. The goal is to identify issues related to cancer prevention, access to care, screening and treatment services. At each forum, ISDH staff will present regional cancer data, followed by comments from the public. Health professionals, legislators and other local leaders are being encouraged to participate. Information gathered will be used in the state cancer plan and in planning legislative and program interventions.

Dates of the remaining seminars are: Sept. 17, Gary, Barbara Wesson Center; Sept. 22, Richmond, Holiday Inn; Sept. 23, Indianapolis, ISDH office; Sept. 24, Terre Haute, Holiday Inn; Oct. 1, Evansville, Radisson Inn; and Oct. 8, Jeffersonville, Ramada Hotel. All forums will begin at 6 p.m. For more information, call Sue Foxx, (317) 633-0297.

Mental health teleconference to examine research needs

"Breakthrough '92," a mental health teleconference, will be held Saturday, Oct. 10, from 10 a.m. to noon at Indiana University-Purdue University at Indianapolis. Participants will include people in 127 countries, who will examine the need for increased mental health research. To register for the teleconference, call Jon Barnes at the Mental Health Association in Marion County, (317) 251-0005. □

ELECTRONIC

CLAIMS

S U B M I S S I O N

...

*Erica*SM

AdminaStar
Electronic Services
a division of AdminaStar, Inc.

THE ERICA FAMILY OF PRODUCTS CONNECTS INDIANA HOSPITALS AND PHYSICIANS WITH SYSTEMS AND PEOPLE WHO CAN HELP MANAGE YOUR OFFICE'S MOST IMPORTANT OPERATIONS-CLAIMS, INQUIRY AND REMITTANCE. BETTER. FASTER. AND MORE EFFICIENTLY.

OUR NEW CLAIMS SOFTWARE, FASTEMC, LETS YOU BILL HCFA 1500 AND UB 82 CLAIMS ON ALMOST ANY COMPUTER PLATFORM.

**CALL TODAY FOR A
FREE DEMONSTRATION**

**THE PEOPLE WHO PRACTICALLY
INVENTED ELECTRONIC CLAIMS**

1.800.
437.4221

Health Policy Commission report alarming

John A. Knote, M.D.
Lafayette

Editor's note: See related article on page 378.

The final report of the State Health Policy Commission is due in November after a three-year study of the health care delivery system in Indiana. The early draft report of the commission should alarm all Indiana physicians. The report is onerous, not only by what it includes but by what it omits.

The State Health Policy Commission proposes that Hoosier medical care be provided in a managed care system by primary health care teams that contract with or refer to allied health professionals and specialists. The "health teams" would be managed by primary care physicians and would be reimbursed either by salary or a capitated rate. Patients with critical illness – some 3% of health care consumers, who spend 37% of health care dollars – would be removed from the primary care system under the proposal. In effect, the commission is suggesting that the entire health care system in Indiana be scrapped for those 3%, while simultaneously removing them from the system.

The report does not mention that 40% to 60% of health care dollars (depending on the source of information) is spent on drugs, durable medical equipment, nursing homes, legal activity, research and education and advertising by health care facilities. The plan fails to address the formal participation of patients in the cost of their care. Another major shortcoming of the plan is the lack of

knowledge and discussion about the amount of money expended for various groups of illnesses and medical procedures. No health reform plan will succeed unless these three factors are addressed.

The overall tone of the report should be disconcerting for physicians. It alleges that "health care providers are not held accountable for their services by any guidelines, standards or comparative norms." That statement is entirely false. Considering the current legal system, managed care programs, PRO review, Medicare mandates, hospital peer review and medical staff recertifying, physicians in Indiana (and elsewhere) are held more accountable than any other profession.

The commission proposes to counteract this "lack of accountability" with clinical evaluation panels. The panels, beginning with the 10 most costly and the 10 most utilized procedures, would study and implement practice guidelines for each of those areas. This approach is grossly redundant and unnecessarily costly, since approximately 1,300 practice parameters (guidelines) have been developed already, and nearly 200 currently are being considered by the AMA Partnership on Practice Parameters, the Forum on Practice Parameters and the government-funded Agency for Health Care Policy and Research. Furthermore, the proposed practice guidelines would not provide an absolute legal defense in medical liability cases even though the physician followed the guidelines promulgated by the clinical panels. There is no appeals mechanism for physicians to challenge decisions of the clinical panels in this proposed "plan."

The clinical evaluation panels also would study new procedures and attempt to determine which are most cost effective and appropriate before they become common practice. The State Health Policy Commission has no figure for the cost of reviewing all the data, nor how such a cumbersome process might limit the use of new technology, which could be more cost effective and/or save patients' lives.

Although some doctors will serve on the clinical panels, the proposal suggests that a non-profit corporation, made up primarily of consumers, oversee the system and choose the clinical panels. The proposed system is to be financed by a global budget determined by "policy panels." The report calls for a health care budget reduction of 1% below inflation for each of the next 10 years until the inflation rate is reached. Ostensibly, the budget is not to be used to deny needed medical care. However, the state cannot establish and pay for an entire new system (with progressively reduced funding) without rationing medical care.

Parenthetically, the physician presenting this draft proposal to the ISMA Executive Committee said that there were no political considerations in the plan, but he later acknowledged under questioning that the plan would not be released until late November for "obvious reasons." In addition, his presentation to the ISMA included a suggestion that private insurance would be de-emphasized under the commission's plan.

Proposed changes in physician licensing is another component of the report that is very troubling. Most of the proposed

licensing corporation board members would be consumers. Consumers cannot adequately determine competency, medical education requirements and scope of practice for physicians. A huge potential conflict of interest may be present because the corporation would be financed, in part, from the penalties it levies.

One can appreciate the exten-

sive material reviewed by the State Health Policy Commission during the past three years, but the ISMA cannot support most recommendations to date. Health care reform is ongoing, and the process is supported by the ISMA and AMA. However, the solutions proposed by the commission should be vigorously opposed because it will not allocate limited

health care dollars effectively, and its limited emphasis on quality of medical care will not be acceptable to patients throughout Indiana. □

Dr. Knote is a past ISMA president and a member of the AMA Council on Medical Services.



SAFE
EFFECTIVE
CONVENIENT
ECONOMICAL

Mono-Gesic[®] R Tablets
(750mg Salsalate)

A well tolerated
Salicylate Therapy

C[®] CENTRAL PHARMACEUTICALS, INC.
SEYMOUR, INDIANA 47274 USA
Quality Pharmaceuticals Since 1904

Selected demographic changes in medicine

George T. Lukemeyer, M.D.
Chairman, Editorial Board
INDIANA MEDICINE

Dramatic changes in the demography of medicine and medical education have been unfolding for more than a quarter of a century. The full impact of this continuing revolution has failed to excite the interest of either the profession or the public.

In the late 1950s and early 1960s, there was widespread concern about the physician shortage and its accompanying problem of geographic and specialty maldistribution. The United States physician-to-population ratio was 143:100,000, and the Indiana ratio was 97:100,000. There were 86 U.S. medical schools and 8,298 entering medi-

cal students in 1960. In that same year, the entering class total at the Indiana University School of Medicine (IUSM) was 188.

An aroused public and profession stimulated governmental programs and private support designed to increase the number of medical schools and to expand the enrollments of existing schools. Many of the expansion programs featured an increase in the number of primary care physicians as their avowed mission.

By 1970 there were 103 U.S. medical schools and 11,348 entering students. The IU School of Medicine admitted 242 matriculants to its emerging decentralized statewide medical education system. Ten years later, there were 126 U.S. medical schools with 17,204 entering matriculants. Indiana, with its exciting statewide

medical education program, enrolled 305 first-year students.

In 1991, the nation's 126 medical schools admitted 16,211 new students, and the IUSM's entering class totaled 265. Currently the physician-to-population ratio is 237:100,000 in the U.S. and 171:100,000 in Indiana.

The Indiana experience fairly closely reflects national trends.

Let's now focus on the trends of female applicants and matriculants. Before 1965, women made up less than 10% of medical school applicants and matriculants. The total number of applicants and matriculants increased precipitously and antedated by several years the surge in applicant numbers anticipated by the post-World War II baby boom. Following 1970, the number and percentage of female applicants

Table

Medical school applicants and matriculants

	1982	1986	1990	1991
Female (U.S.)				
Applicants	11,685 (33%)	11,267 (36%)	11,785 (40%)	13,700 (41%)
Matriculants	5,201 (31%)	5,574 (35%)	6,153 (39%)	6,433 (40%)
Total (U.S.)				
Applicants	35,730	31,323	29,243	33,301
Matriculants	16,567	16,103	15,998	16,211
Female - Indiana University School of Medicine				
Applicants	439 (32%)	361 (35%)	580 (35%)	845 (39%)
Matriculants	102 (35%)	83 (31%)	90 (34%)	100 (38%)
Total - Indiana University School of Medicine				
Applicants	1,372	1,041	1,657	2,178
Matriculants	290	265	265	265

and matriculants progressively increased. Applicants peaked nationally at 42,624 in 1974, and Indiana resident applicants to the IUSM reached a record high of 853 in 1973. Medical school enrollment and growth rates far outpaced population growth. Some careful observers in the mid-1970s expressed concern that a doctor glut was imminent.

Shortly after the Vietnam War ended in 1974, applications for medical school declined although enrollment figures remained high. Women accounted for approximately 15% of medical school applicants and matriculants in 1974. Since 1974, there has been a precipitous drop of more than 50% of white men in the applicant pool. Concomitantly, female application rates accelerated as did their admission to medical schools. The increases in female applicants softened the impact of the unanticipated plunge in the number of white male applicants. Examples of this trend are depicted in the *Table* by the data on applicants and matriculants by gender for selected years for U.S.

medical schools and for the IUSM.

After a 14-year decline, the applicant pool stabilized in 1988 at 26,721 in the U.S. and 1,126 at the IUSM. A pleasant unexplained increase in total applicants has followed in the three subsequent years. It is important to remember, however, that nationwide there are still 9,323 (22%) fewer candidates than the peak year of 1974.

The changing number and gender mix of medical students have had an impact on graduate medical education (residency training). Today there are approximately 6,622 Accreditation Council on Graduate Medical Education-accredited programs with roughly 90,000 trainees. Resident positions increased by 10,000 from 1980 to 1985 and again from 1985 to 1990. During this same time period, the PGY-1 positions have decreased by 2%. The overall increase in program numbers and trainees is the result of the lengthening of the time for established programs and the proliferation of new specialty residencies and fellowships.

The proportion of women residents increased by 7% from 1980 to 1990, and women now account for 30% of all residents. Further increases in the number and percentage of female residents can be anticipated as a result of the continuing success of female applicants for admission to medical school. Most women residents still are found in internal medicine, pediatric and family practice residencies. While women have traditionally selected primary care residency training programs, they are selecting an ever increasing spectrum of programs in other disciplines.

It would be interesting to speculate on the future impact of women in medicine. It is clear that in the coming years we will see an increasing number of female colleagues in our medical schools, on our faculties and as practitioners. Medical schools and the profession should redouble efforts to attract and retain the best individuals to medicine without regard to gender. □

■ letter to the editor

State funds needed for proper care of Central State patients

An analysis of Central State Hospital in Indianapolis following the deaths of several patients revealed that there were chronic shortages or poor deployment of professional staff and long-standing maintenance issues. There were serious concerns about whether patients were able to be cared for safely, and whether constructive treatment was taking place.

The Family and Social Services Administration and Robert Dyer, director of the Division of Mental Health, recommended that patients be relocated within the next 24 months based on national and state data affirming that community-based care is always favored over institutional care. Gov. Evan Bayh ordered the hospital to be closed and asked several agencies to begin planning for the transfer of approximately 295 of the 370 patients into the community.

Long before it became popular to suggest that the decision to close Central State was politically motivated, service providers, advocates and consumers of services were trying to get it closed. The quality of life in the state hospital is poor. Reports from the JCAH review committees, the Indiana Advocacy and Protection Agency, patients, patients' relatives and staff provide evidence that many employees are lazy and uncaring and frequently emotionally abuse and ignore the patients they are paid to "care" for.

We are at a significant crossroads in deciding how we will provide care for the seriously mentally ill who live in Indiana. It's hard to acknowledge that we haven't done all we could to guar-

antee the safety and quality of life for people who depend on us to care for them.

It is easy to forget their plight because they are behind closed gates and locked doors in a state hospital. Only when they die from neglect are we forced to really look at them and their situation. Then we are faced with the terrible fact that we have forced vulnerable, seriously ill people to live in an environment in which we would never want to see our own family or friends have to live.

It's interesting to me that one of the popular choices for a future use for state mental hospitals is as a prison for convicted criminals. For all these years, people who committed no crime and whose lives have been devastated by a terrible mental illness have been forced to live in an environment that is now considered suitable only for criminals.

This situation says some hard things about our society. We continue to place other things before the lives of human beings who are not responsible for their illness and for their great need of our caring support. People say it all comes down to enough funding, but that's not true. It all comes down to caring enough.

Long-term hospitalization of the seriously mentally ill may always be necessary, given the severity of symptoms some people experience, but it's when, where and how that hospitalization takes place that is at issue with the closing of Central State.

Proponents of community-based services, like myself, have the opportunity to prove that more humane and appropriate treatment can take place without relying on large state hospitals.

Presently the treatment knowledge exists that would allow patients who have severe mental illnesses to live in their community and receive the wrap-around-services they need to manage their lives successfully.

Ron Riggs, director of the Danville Mental Health Center and one of the coordinators for the transition of patients from Central State into the community, said, "The community mental health centers do not presently have the capability of serving the people who are at Central State. There have never been enough funds to develop the kinds of secure environments in a residential setting, nor the sophisticated wrap-around-services that will be needed for many of these patients. Client tracking systems are going to be critical, as are aggressive case management guidelines."

The state must ensure the safety and well-being of the mentally ill people who will be transferred from Central State by adequately funding and planning for the necessary community services. The monies must follow the client rather than going to the programs.

Although the governor's administration would lead the public to believe that the Medicaid Rehab Option will be the solution, recent assessments indicate that it will only add about 10% to the present community mental health center budgets.

Advocates for the mentally ill share the concern of Steve McCaffrey, executive director of the Mental Health Association, that "unless the state adequately funds the downsizing of state hospitals and the transfer of patients into appropriate community placements, the closing of Central State will be devastating for those

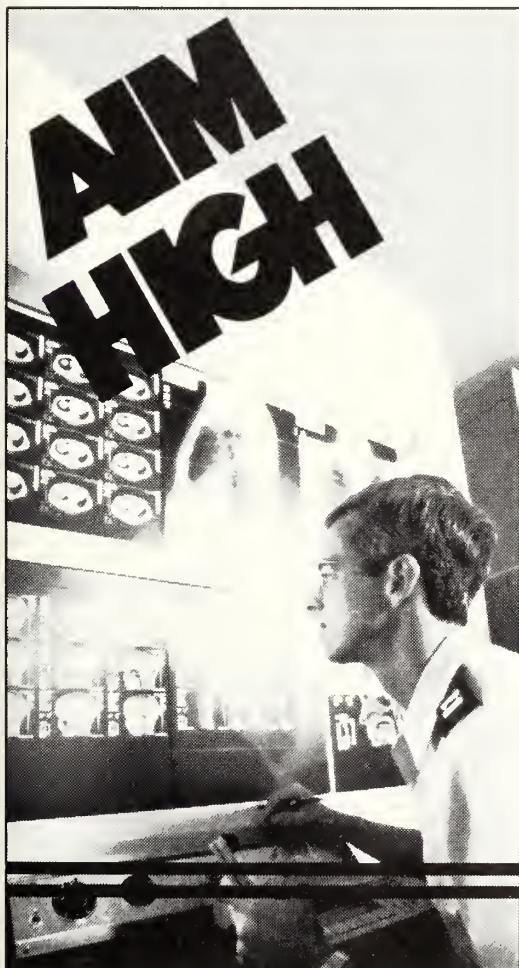
■ letter to the editor

patients."

As a long time advocate for the mentally ill, I am very excited about the decision the state has finally made to make quality community-based care for the seri-

ously mentally ill a priority. But the public has a great responsibility to ensure that the state appropriates the funds so that community-based services can be successfully implemented. □

Janice Herring
ISMA staff and member of the Governor's Commission to Study the Long-Term Needs of the Mentally Ill and Developmentally Disabled



SPECIALIZE IN AIR FORCE MEDICINE.

Become the dedicated physician you want to be while serving your country in today's Air Force. Discover the tremendous benefits of Air Force medicine. Talk to an Air Force medical program manager about the quality lifestyle, quality benefits and 30 days of vacation with pay per year that are part of a medical career with the Air Force. Find out how to qualify. Call

**USAF HEALTH PROFESSIONS
COLLECT
(317) 848-5830**



Woman physician

Bob Carlson
Indianapolis

The American Medical Association has designated September as Women in Medicine Month. To obtain a perspective on the progress of women in medicine, INDIANA MEDICINE talked with Doris H. Merritt, M.D., one of the few women who entered the medical profession before there was such an observance as Women in Medicine Month.

At that time, there were very few women in medicine. Even as late as 1970, only 7.6% of physicians in the United States were women. By 1990, that proportion had increased to 16.9%, while the actual number of women physicians had more than quadrupled from 25,401 to 104,194. In the year 2010, the AMA projects that almost 30% of all U.S. physicians will be women. But 40 years ago, medicine was decidedly a male profession – with a few exceptions.

Dr. Merritt was one of those exceptions. Currently professor of pediatrics and associate dean at the Indiana University School of Medicine and special assistant to the president of Indiana University, Dr. Merritt graduated from the George Washington University School of Medicine in 1952. Her subsequent education included an internship in pediatrics at Duke University Hospital, a teaching and research fellowship at George Washington University School of Medicine and then a return to Duke University Hospital as pediatric assistant resident and fellow in pediatrics.

After three years with the National Institutes of Health (NIH), Dr. Merritt came to the Indiana University School of Medicine as director of medical

research grants and contracts and assistant professor of pediatrics. She returned to the NIH in 1978 as special assistant to the director and, concurrent with that position, was research training and research resources officer from 1980 to 1987 and acting director of the National Center for Nursing Research from 1986 to 1987. She returned to the IU School of Medicine to assume her current position in 1988.

Dr. Merritt holds numerous local, national and federal government appointments and consultantships and is widely published. She has received numerous awards and is a member of several honorary societies, including Phi Beta Kappa. Her biographical listings include "Who's Who in America" and "Who's Who of American Women."

INDIANA MEDICINE: What contributed to your decision to go into medical research?

Merritt: I had graduated from college with a major in English literature and a minor in philosophy. And that doesn't allow you to do very much. Certainly in 1944, it allowed me to do one of two things. One was to teach – that was the traditionally respectable alternative – and the other was to go into some sort of sales. However, that was also while World War II was going on and the recruiters for the Navy were visiting the various colleges and recruiting those who graduated at the top of their class for officers training school, and I got swept up into that.

As the war came to an end, it was pretty clear I had to support



sees need for mentors

myself and decided it would be law or medicine because I wanted something that was interesting. And that was based on the fact that most of the young women going into the Navy that I met were getting dead ended where they found themselves, in teaching or in retail. Very few were getting into radio, there were one or two of those. But it was rather a closed situation for girls who wanted a career.

My father was an attorney. He told me at the time that life was very hard for women lawyers and he thought I'd get a squarer deal if I went into medicine. So I got a few catalogs, realized I had two years of pre-med work to do, went through pre-med and was admitted to medical school. At that time, it was to be a doctor - I knew nothing about research.

In our class of 90 students, we had three women and, frankly, we had a very good time. It was not a matter of prejudice, it was fun. People were nice to us. We worked hard and we took our share of teasing but it was all right.

When I graduated from medical school, I had the good fortune to intern at Duke University, and

there the emphasis was very, very strongly on research. Therefore, we were all expected to do some, even while in clinical training, and I eventually found myself in the laboratory. The work resulted in several publications in respected journals, but I didn't like doing it. I much preferred the clinical end of things.

By then, I was married and my husband was aiming for the National Institutes of Health for a few years. We went to the National Institutes of Health where, for a variety of reasons of timing, I got into research administration. And, that was it. I'd found the

“ *As the war came to an end, it was pretty clear I had to support myself and decided it would be law or medicine because I wanted something that was interesting.* ”

right niche.

That was in 1957, when the NIH was just beginning to enter the grant-making business in a big way so that anybody who wanted money for health research, certainly, came to the NIH. It was a system that required, and still does, what they call a dual review of applications, where the technical review is done by a group of, they call them peers but believe me, they're larger than life as far as peers are concerned. As an executive secretary, I was working

with a Nobel laureate, Andre Cournand, and Homer Smith, the dean of renal physiology. And for a young woman, wide-eyed, out of clinical training, this was the most exciting experience I had had, and I stayed with research administration.

What I discovered was that I like to help people smarter than I am get things done. And certainly, that was a marvelous place to help people get things done.

INDIANA MEDICINE: Research-wise?

Merritt: Research-wise. When we left NIH in 1961 to come to Indiana, I was brought into this same office, two doors down. The job, which turned out to be assistant dean of the School of Medicine, was to help people get funded to do research. At that time, our grant income here was just under \$2 million a year. Today it's almost \$60 million.

I think you have to understand that I never really considered myself an investigator. I published and I made my bones, as they say, so that I understood what it was like to work in the laboratory and do original research. But I was never an investigator that made a career of research.

INDIANA MEDICINE: You have such a wonderful perspective on the field of medicine and women in medicine. Can you give us an overview on how the field of medicine has changed for women since you graduated?

Merritt: The field of medicine has certainly changed and the numbers of women in the field have changed. I don't think the two



are connected. The number of women entering medical school 40 years ago was someplace in the neighborhood of under 5% of the total medical school population. Of course at that time, there were only 16,000 individuals in them. Today, however, 40% of every entering class is composed of women. And that simply follows, it seems to me, the socialization of what women do.

I believe that today women are admitted to medical school in the same proportion in which they apply. In other words, there's nothing biased against them in terms of their entering medical school. Now, traditionally, in the early days, women went into the so-called women's specialties, like pediatrics. There were a lot of women pediatricians. You almost never heard of a woman surgeon. You did hear of women in OB-GYN and anesthesiology. Today, there's hardly a field that women can't enter and don't enter. And I think that's a matter not so much of acceptance of women as acceptance of the fact that that's the way it's done. Maybe it is acceptance.

INDIANA MEDICINE: Did you have a woman mentor or role model who helped you advance in your career?

Merritt: No, there were none. The men I worked with were extremely helpful. They really were. And this has nothing to do with a sexual relationship. Sure, I was a pretty kid and some people made passes, but you learned to deal with that fairly quickly.

But I like to think that I always did more than I was asked to do. I was never really told to

very much. I was frequently thrust into a situation where there was no precedent. I was made an assistant dean for research when no one knew what that meant. I had to develop my own job description. I had some ideas of how to help people get more research grants, organize programs and get more money. Dr. Van Nuys, who was dean of the school, was completely supportive.

Herman Wells was equally wonderful. I would have to say that what Herman told me early on was something that's guided everything I've done ever since. I went to him one day and said, "Mr. Wells, we just have to have more money; this is falling apart. The whole thing is going to go; we're going to be in a terrible mess." He said, "Doris, Doris, you stop right there. Crisis and destitution never got you any place. You talk about opportunity and potential, the future and what you're able to contribute." "Crisis" and "dstitution" have never passed my lips again.

The other thing I took to heart from Mr. Wells was when I once said to him "I have an idea that some people are interested in that's not quite what we've been doing in the past. Would you support it?" And he said, "I'll support any good idea [that] you find somebody to finance." And that's about the way it went. Now, with that kind of person behind you saying just go and do what's right, it's hard to fail. And that's the way it happened. People have just been very accepting. It makes me a little impatient with the whiners.

INDIANA MEDICINE: It makes you

impatient with the whiners?

Merritt: Yes. And that's all right. I've never hidden how I felt about that. Now, that's not to say that there isn't bias. There has certainly been bias, and I've seen it. I've seen it primarily in relation to salary, where in fact women were not paid the same amount as men were paid.

As a matter of fact, when my husband and I first came here, with exactly the same credentials, he received \$1,000 a year more than I did. It was explained to me, somewhat apologetically, that the university felt it looked as though they were paying too much to a couple. So they cut it down by a thousand. They cut mine back because I was a woman.

A similar thing had happened at Duke the last year I was there as a cardiovascular fellow. I received \$3,600 a year and my husband was receiving \$1,800 as chief resident in medicine. It's the only time I ever made more money



than he did. I was receiving \$3,600 as a fellow to run the pediatric cardiac clinic. When I left, the young man that replaced me got \$7,200, and I went raging to the department chairman, whom I thoroughly respect by the way, who was a superb teacher and mentor and normally very supportive. But I said to him, "How do you dare do that?" And he said, "He has a wife and two children to support." My baby and child care bills didn't count, I guess. Again, that was 1957. He couldn't do that today. You couldn't do that today. However, I didn't whine about it. I yelled a little, but it was after the fact. I didn't whine about it, and we're still friends.

After that I got into the federal government and, at that point, everything was pretty even, and I was promoted pretty quickly, and I had no complaints.

INDIANA MEDICINE: How important is it, do you think, today, for a woman in medicine to have a mentor?

Merritt: Today, I think it's terribly important.

INDIANA MEDICINE: More so than when you were starting your career?

Merritt: Yes. I think even more so. When you consider that there were only three women in my medical school class and that there were proportionally few women applying for medical school, you have to think that we had some exceptional stubbornness or tenacity or just plain ordinariness, that they were going to do it regardless. And perhaps in

that sense the need for a mentor was less.

Today, it's very acceptable for women to go into medicine. It's acceptable, at least, once you get out of the high-school-gee-you-think-you're-so-smart peer area. I think it's an accepted thing. It's not strange for a woman to say she wants to be a doctor or a lawyer or even an engineer.

INDIANA MEDICINE: So why is it more important to have a mentor today?

Merritt: I think it's harder for women today in that they're now a force to deal with. They have

“
I think it's harder for women today in that they're now a force to deal with. They have more options and they need somebody to look to ...
”

more options and they need somebody to look to [who can say to them], yeah, life is hard and you have to accept that life is hard. You can do it; you can make it. It's possible.

You've asked a very good question. I think it has to do with personality. Some women don't need mentors. But it sure makes it easier to have a network.

INDIANA MEDICINE: What kind of advice might you give a woman about finding a mentoring personality in her career?

Merritt: Oh, just looking at the people around you who are practicing medicine or who are in medical school and knocking at the door just ahead of you. Most of us keep our door open to young people who want to talk to us – men or women.

Now, young physicians coming along today who are trying to manage an extremely heavy training burden, many of them are married. Many of them have spouses who are in the same situation. I think they just do better if they can look ahead and see that there are people who have managed and that they can do it too.

They also need somebody who does what mentors do, refer you to other folk and tell you when opportunities become available. A mentor is really somebody who takes you in hand and says, "I'm going to help you with your career, and I'm going to advise you every step of the way, where you need help, and I'm going to put you in touch with things that you need to be put in touch with."

Men have had this for years. That's the old boys' network. Somehow or other, before we were such a minority, I think fortunate women like myself were treated as part of the old boys' network. I mean people referred me on, they were helpful. You did good work, and you got promoted.

INDIANA MEDICINE: You're almost making it sound like it was a bit easier for you, back then.

Merritt: Because I wasn't a minority. I was an exception. Today women are a minority, and they have to fight, in a sense, for

minority rights. I believe that.

INDIANA MEDICINE: **An exception rather than a minority?**

Merritt: Yes. And everybody tolerates exceptions pretty well, particularly if they carry their own weight, and we did. Now that isn't to say that nobody ever called me "dearie" or patted me on the head or anyplace else, but it wasn't an issue. The climate was different. We were working in a profession. We weren't, or people like me were not, seeking recognition as a sex. We joined a discipline, we were working in that discipline, we wanted to be judged by that discipline.

If we get into the business of women's rights, that's another story. It was a hot issue that still attracts extremists and only started to cool off in the '80s. But, it was a real problem where men that I'd worked with all my life would suddenly bite their tongues because they were afraid that they'd offended me by some kind of remark, which was casual banter. That's past, thank goodness.

But, it was pretty sad when a man would open a door for you and then sort of recoil as though, "I shouldn't have done this." And that happened for a while. That really happened. People were terribly, terribly hypersensitive. And, in some instances, they should have been and still should, but in others they shouldn't. The whole thing got out of whack. It got out of perspective.

INDIANA MEDICINE: **What can women role models such as yourself do to help younger physicians, women physicians, advance in their careers?**

Merritt: Well, I think for one thing, we're proof it can be done. And we can do it with grace. We can laugh at some of the things that aren't always laughable. We can help people get through hard times. I'm a grandmother. We can show it can be done.

I think probably one of the things that we can't do is to tell people you can have it all easily, because you can't. It requires a lot of hard work, and you have to be willing to work hard. Nothing's going to be handed to you on a platter, and you can't expect that it will. But, I do believe that if you work hard, most of my colleagues behaved like gentlemen. They appreciate quality. I've never felt trampled on.

“
... One of the things that we can't do is to tell people you can have it all easily, because you can't. It requires a lot of hard work, and you have to be willing to work hard.
”

INDIANA MEDICINE: **Would you say there are certain areas in medicine where the need for a role model for women is especially urgent?**

Merritt: Depends on what you would like your women physician to be. Today there's a great need in medicine for primary care physicians. And in many ways,

women are very suited to primary care and family physician worlds. Our own chairman of family medicine is a woman. It just seems to be that some women have more of a nurturing capacity than some men do. And that's not to stereotype women or men. It's just that if you take the whole spectrum, women seem to be, in a way, just by virtue of the way we're reared, a little bit more compassionate in many areas, and less afraid to show it. And I think that's all to the good.

INDIANA MEDICINE: **Women do tend to go into some of the primary care fields in higher percentages than men. So when I ask "are there certain areas where the need for role models is especially great ..."**

Merritt: It depends on what you want to role model. Do you feel that surgery would be better, for example, if there were a lot more women surgeons? I don't know. Certainly, there are fewer women surgeons than there are male surgeons. On the other hand, OB-GYN is a surgical sub-specialty and without knowing the statistics for it, I understand there are many women going into OB-GYN now and doing very well at it. Seems to be a natural kind of thing for women.

INDIANA MEDICINE: **Did you ever feel discrimination or gender bias as a student or during your career?**

Merritt: Yes, but I didn't know what I was feeling. I didn't recognize it as gender bias, let me put it that way. I assumed it went with the territory. If I were in a

class in urology and people, even the professors, would make asides, I figured that was just part of the game. And I wasn't going to get ruffled by it. But most men were gentlemen. Rudeness was the exception. That wasn't the rule.

INDIANA MEDICINE: *Is that a factor in the current concern about gender bias or discrimination, a lack of gentlemanliness?*

Merritt: No. I think maybe more competition is more like it. You see, when you have three women in a class of 88 men, you're really not much competition as a sex. You may be an oddity, but you're not really considered group competition. And remember we were very bright. So we could keep up easily. It wasn't a question of having to fight for your place.

Now when you have a class of 100 with 40 women and 60 men, everybody's competing, more or less equally, and it makes a difference. There are enough



women to be looked at as a group, an influential group with clout. You don't have a couple of women in a class of men. It's very different. It changes the whole aspect of it.

And then, remember, we have just come through a period of time when people were forced to give preference to women simply because they were women. And that didn't make our male colleagues like us very much either. Of course, some would have said they'd always had preference because they were men and they were getting a taste of what discrimination was like. That's a battle I have never joined. My own experience has been that if you're capable, you're recognized as being capable.

INDIANA MEDICINE: *Regardless of gender?*

Merritt: Regardless of gender. You understand that it's very difficult for me to listen to women say, "I didn't make it because I was a woman." I did make it, and I am a woman. And I was not terribly unusual. I just did what I thought was expected of everyone.

INDIANA MEDICINE: *Do you believe discrimination and sexism exist in medicine today?*

Merritt: It exists everywhere else. Medicine is no exception. It may be a little less in medicine. We're more highly educated. One would like to think we have less discrimination.

INDIANA MEDICINE: *What sorts of phenomena come to mind when terms like discrimination and*

sexism come up?

Merritt: Oh, I'll go back to the National Institutes of Health in the '60s, the late '50s. It was very clear that the absolutely superb director of the NIH, Jim Shannon, simply did not believe that women could hold leadership positions. He would not appoint a woman to a leadership position. You don't hear that today. It may still exist, but you don't hear it today. No one would dare say it out loud today.

INDIANA MEDICINE: *What will it take to discourage discrimination against women in medicine?*

Merritt: Very capable women. I don't know that I have ever been discriminated against other than on salary issues and, in retrospect, that was my fault. When I finally tackled the problem, it was resolved.

INDIANA MEDICINE: *Well that's not an insignificant thing, is it?*

Merritt: No, not at all. That was in the early years. There are more laws now, thank goodness.

INDIANA MEDICINE: *I'm sure you're aware that there are still disparities.*

Merritt: For equal rank and equal training? I think what we're seeing in medicine, if you look at aggregate statistics, is that women are entering academic medicine now in an increasing stream and because they're just entering the profession, they are at lower ranks. Lower ranks naturally receive less salary than higher ranks. I like to think that's the

case. I would like to think that the efforts over the past 10 years have raised women's salaries so that there is parity between what a woman does and what a man does.

INDIANA MEDICINE: **You see it more as a function of rising through the ranks as opposed to discrimination?**

Merritt: Yes, I do. Now is there something that prevented women from rising through the ranks? There were very much fewer of them. Again, look at the figures. I was one of three in a class of 88.

I would hope as we move along that when somebody is interviewed 25 years from now in my position, if there are 40% women in medical school, there will be 40% women on the faculty, and that 40% women will be treated the same way as the 60% men. I believe that's happening.

While I was at the National Institutes of Health, it was very clear that there were not as many women investigators as there were men investigators. Of course not. But when I started plotting the numbers of women graduating from medical schools and those getting Ph.D.s and looking at the slope of women entering academic medicine, it seemed to me that the slopes were parallel. In other words, it takes time to fill the pipeline.

INDIANA MEDICINE: **Above and beyond the demands of career and family, there's a third issue that seems to come up and that is isolation in a male-dominated profession.**

Merritt: People like myself prefer

to be with the mainstream, and again, this is just prejudice. I was a doctor and I wasn't willing to isolate myself as a woman doctor because the group was so small. It didn't make sense. It is better to think of yourself as a doctor, rather than as a woman doctor or a man doctor.

I'm sure that if I were smart enough as a psychologist, I would recognize that there is a women minority personality and a need to fight for minority rights which, because I never considered myself a minority, I was untouched by. Maybe I was just not thinking

“
I would hope as we move along that when somebody is interviewed 25 years from now in my position, if there are 40% women in medical school, there will be 40% women on the faculty, and that 40% women will be treated the same way as the 60% men.
”

about anything but the responsibilities of the day.

I was just a girl in medical school. I had a ball. But remember, we're talking about 40 years ago. And a lot of things have changed in 40 years.

INDIANA MEDICINE: **Have they gotten better or worse?**

Merritt: Just different. It never occurred to me that I was doing something remarkable. I was just doing medical school. I felt lucky to get in; it's what I wanted to do. I wasn't fighting for my place in the sun, I wasn't fighting for any particular rights. I just wanted to go to medical school and graduate.

I wasn't living in a world where we have chief justices being assailed for sexual discrimination. I wasn't living in a world where if somebody told me I was wearing a pretty dress or looked good that I was supposed to take affront because it was a sexual remark. It was much easier, very much easier. I guess I wasn't fighting for any rights. I was just blissfully unaware, when you come right down to it, that there were rights to be fought for.

Now, that's not at all to say that I don't think women have a need to fight for equal recognition. As more and more capable women enter the profession, they become more and more of a threat. And when you're facing a group of competitive men and women, there's got to be some squaring off. There was always fierce competition among professional men. When you add the man/woman mix, it doesn't change the reality of looking for a competitive advantage. But the advantage should be related to ability not gender. That's really what women are saying. We're looking at a sociological change.

INDIANA MEDICINE: **Medical researchers have traditionally conducted studies on men. Will more women research physicians be needed before the number of studies specifically on women's**

health issues increase?

Merritt: No, I don't think so. Right now, the National Institutes of Health is making it very clear that you have to choose your clinical populations according to disease and not according to gender.

The reason for working more on men than on women in the past when doing clinical studies is that researchers didn't want to deal with the complications of the menstrual cycle or of women getting pregnant and doing something in the course of the study that would be deleterious to the fetus.

I think it's been made very clear that wherever possible, women subjects should be used in the same proportion as men and there should not be more research done on men than on women. And that is coming to pass. There's no question about that. Truly basic research is applicable to both sexes.

INDIANA MEDICINE: As more women enter the field of medicine, how will the delivery of medical care change? Do you see any trends?

Merritt: I think that what's changing the delivery of medical care has nothing to do with the

sex of the physician. What's changing medical care is economics.

INDIANA MEDICINE: What do you see in the future for women physicians in practice, in research, or as teachers?

Merritt: I think it's a wonderful future for people who are well prepared and eager to work. I think it's always been a wonderful future. And I have to say I think it for men and women. Capable people rise to the top. And people who work hard and do their jobs well tend to get where they're going. That isn't to say that you don't have obstacles. Nobody has it all smooth. Men don't either.

Our society is changing. My grandfather was a physician. He died at the age of 38 of coronary heart disease. Coronary heart disease was called the doctor's disease. We're better off now. We don't work quite the same hours. As the whole spectrum of how health care is delivered changes, it will be a little easier on physicians in terms of the hours that have to be worked. It should make it a little simpler to be good parents.

Society is changing, not just medicine. Medicine's changing is part of societal change. You've

got workaholics everywhere. That's not gender-dependent. It'd be fun to come back in 50 years and look. I've heard people say that medicine will be a gentler profession because more women are entering into it. That's nonsense, too. I've known some very gentle men and some very hard women.

I think we've come through a period of time in the past 15 years when women did have to fight to enter the profession. Today, we should be largely past this stage and able to address the next steps: How do we grow in stature? How do we work together? How do we make this a better profession?

Practically speaking, it cannot help but change the way medicine is practiced to have 40% of the practicing physicians women. There is more than a "vas deferens." A woman's outlook is different. And they will bring different attributes to the profession just as men bring different things to it. I think it will be a healthier profession for a better mix. And that's what it's all about anyway, health. ▽

This interview was conducted by Bob Carlson, a health care communications consultant in Indianapolis

Commission studies Indiana health care delivery

Jean Terry
ISMA Legislative Assistant

Editor's note: See related editorial on page 364.

In 1989, the Indiana General Assembly found it was overwhelmed with health care issues, including the increasing cost of care, the number of uninsured and underinsured Hoosiers and reductions of the Medicaid budget. In attempting to deal with these complex issues, legislators created the State Health Policy Commission to study the effectiveness of Indiana's health care delivery system programs and to chart a course for the health policies of the future. Specifically, the commission was asked to focus on access to health care, the cost of health care and preventive health care.

The commission is made up of 17 voting members, who were appointed by the governor and legislative leadership. The commission is comprised of the following: five legislators, two representatives of the insurance industry, one pharmacist, one drug company representative, two physicians, two hospital representatives (one of whom is one of the five legislators), two members representing unions, two consumer representatives and one nurse. The commission is chaired by L. Ben Lytle, president and chief executive officer of The Associated Group, Inc.

The commission has met regularly, generally twice a month. During the first two years, the

commission members devoted most of their time attempting to educate themselves about the health care system. Experts from a variety of disciplines and interest groups in Indiana and across the nation have made presentations to give commission members various perspectives of the present health care system.

The commission's final report is due to Gov. Evan Bayh Nov. 1, and the commission has begun to put its ideas in writing. The commission is proposing comprehensive health care reforms that would affect every participant in the present health care delivery system: physicians, insurers, hospitals, allied health providers, long-term care givers, employers and patients.

A major theme throughout the commission's final discussions has been the detriments of the current fee-for-service delivery system. The proposal, therefore, works to dissolve fee-for-service reimbursement and proposes capitated payment rates, provider salaries and fixed-fee reimbursement strategies.

With this philosophy driving the commission, it is not surprising that its plan emphasizes managed care. The commission divides care into four categories: primary care, hospital and specialty care, long-term care and critical care. The commission proposes that patients would access health care through a primary care physician who is then responsible for managing the patient's care throughout the delivery process.

Primary care physicians

would be encouraged through financial and contractual agreements to establish a primary health care team. This team would be comprised of at least one physician and may include any number of other allied health professionals. For example, a primary health care team may consist of two physicians, four physician assistants, a nurse practitioner, a nutritionist, an optometrist and any number of other types of providers.

These primary health care teams then would contract with employers and group payors to provide primary care to groups of patients. The primary health teams would be reimbursed either by salary or through a capitated rate. Patients would not be allowed to access specialty services outside of the primary health care team without the referral of the primary care physician. An exception is made for people who are willing to pay a higher co-payment or deductible to bypass the primary care team.

Specific attention is paid to Indiana's critically, catastrophically and terminally ill. The proposal reports that 3% of Indiana's population under the age of 65 is critically, catastrophically and terminally ill. This small percentage of the population uses 37% of the state's health care budget. The commission recommends that better management of this section of the population would result in significant cost savings, \$155 to 250 million per year, to the state's total health care budget.

Thus, the commission recommends the creation of "systems of

excellence." These systems are comprised of "centers of excellence" (hospitals) and "critical care teams" (individual providers). According to the report, "These networks will be developed using a comprehensive credentialing and procurement process developed by an expert medical panel to assure the highest quality yet cost effective providers are enrolled." Patients who meet either a dollar threshold by having spent more than \$250,000 on their health care or who qualify by their particular diagnosis will be removed from the regular health care system and entered into this carefully managed system-of-excellence delivery mechanism. The commission recommends a list of qualifying illnesses, including AIDS, pre-term birth, end-stage renal disease with dialysis, diabetes and cystic fibrosis.

The commission recommends that employers and payors should be more involved in the health care decision-making process. The report states, "The model presented in this report is based on the conviction that health care expenditures must be controlled through setting budget targets and aggressively managing health care expenditures."

The plan strongly suggests that employers and other payors should convene individual policy panels comprised of employees, management and state and community leaders. These groups would decide the level of resources that should be budgeted to fund health care expenditures and how the money should be

spent by each individual employer. The commission recommends that health care budgets should be set at 1% below the prior year's increase for each of the next 10 years until a rate equal to inflation is achieved. The report hastens to add that expenditure targets would not be used to deny needed medical care, but does not discuss how an employer should make determinations when health budgets are exceeded.

In addition to setting expenditure targets, policy panels would

individuals to serve on the various clinical panels.

Appointments to the clinical panels would include all health care providers including physicians, but appointments would not be limited to physicians. The panels would determine practice parameters for the state's health care providers. Providers would not be required to follow the panels' standard-of-care guidelines; however, payors are expected to use the standards when making reimbursement determinations.

Furthermore, physicians who followed the panels' guidelines would not be granted an absolute defense in a resulting medical malpractice case.

The report recommends creating 15 clinical panels, each of which would develop

the standards of practice in a specific health area. For instance, some of the proposed clinical panels include cardiovascular, vision care, infectious diseases, reproductive systems and mental health.

The commission seeks to change the state's current health care licensure system. It recommends establishing a not-for-profit licensing corporation responsible for the licensure of all health care providers in the state, including institutional providers. The board of directors of the licensing corporation would be comprised of multidisciplinary professional and institutional providers plus a majority of consumers. The board would be responsible for creating a number of specialty boards to license individual groups of providers such as physicians, nurses

***Commission members believe
the present health care system
lacks sufficient quality
assessment mechanisms.***

be allowed to review new technology reports and make decisions about whether their individual health plan should cover those new services. Although employers and payors are allowed to bring in medical experts to assist with these types of decisions it is not mandatory. Consequently, non-physicians would make budgeting decisions for employers.

Commission members believe the present health care system lacks sufficient quality assessment mechanisms. They therefore propose establishing a state-run not-for-profit corporation responsible for approving practice standards for providers in Indiana. Under this proposal, the commission recommends appointing 12 board members, one-third of whom would be consumers, to run the corporation and to appoint indi-

and hospitals.

The new licensing corporation would be funded by licensure fees from the health care providers. The board would carry out all aspects of licensure, including receiving complaints, handling investigations and sanctioning the providers. Licensees would be required to meet continuing education requirements established by the board. Licensed health care providers also would have to undergo risk management training.

A major emphasis in this section is provider fraud and abuse.

The commission recommends that the licensing board establish a fraud and abuse unit, which would investigate and bring to the board cases of provider fraud and abuse. The report says, "Acting as a clearinghouse for fraud information, the fraud and abuse unit will solicit information from payors on the providers it is investigating while alerting payors to providers suspected of fraudulent or abusive activity."

One final section of the commission licensing chapter condemns physician ownership of health care facilities. The report

cites several studies showing that physician ownership results in over-utilization by the providers. Therefore, they recommend that Indiana pass a law requiring physician ownership disclosure.

The commission's report is not finalized, and some of the ideas explained in this article may be amended before the Nov. 1 reporting date. ISMA staff will continue to monitor the commission as it finalizes its proposals. If you have questions, call the ISMA Department of Government Relations at 1-800-257-ISMA or (317) 261-2060. □

RBRVS

MFS

E/M

CE

AHPB

CHAOS

CPT

GPCI

RVU

HCEA

GAF

\$30,000 BONUS OFFERED TO HEALTH CARE PROFESSIONALS

If you are a board-certified physician or a candidate for board certification in one of the following specialties, you may qualify for a bonus of up to \$30,000 in the Army Reserve.

**Anesthesiology • General Surgery • Thoracic Surgery
Pediatric Surgery • Orthopedic Surgery
Colon-Rectal Surgery • Vascular Surgery • Neurosurgery**

A test program is being conducted which offers a bonus to eligible physicians who reside in certain geographic areas (Pennsylvania, West Virginia, Ohio, Michigan, Illinois, Indiana, Wisconsin, Minnesota and Iowa). You would receive a \$10,000 bonus for each year you serve as an Army Reserve physician—for a maximum of three years.

You may serve near your home, at times convenient for you, or at Army medical facilities in the United States and abroad. There are also opportunities to attend conferences and participate in special training programs, such as the Advanced Trauma Life Support Course.

To learn more about the Army Reserve and the Bonus Test Program, call one of our experienced Medical Personnel Counselors:

CAPTAIN GEORGE HUGGINS — CALL COLLECT (317) 542-3759

ARMY RESERVE. BE ALL YOU CAN BE.

serenity.

Our accounts receivable management program includes comprehensive service bureau billing, expert profile review and coding assistance, physician reports, and regulatory updates.

Isn't that just what you'd expect from the medical billing expert? Call us today...
you can't afford not to.



3901 North Meridian Street • Suite 200
Indianapolis, IN 46208
IN (317) 923-3046 • USA (800) 527-6244

Doctor fills her life with favorite things

Tina Sims
Managing Editor

INDIANA MEDICINE

Editor's Note: This is the first in a regular series of profiles on Indiana physicians.

Elizabeth Sowa, M.D., has no problem seeing there's a lot in life to enjoy – after all, as an ophthalmologist that's what she's helping her patients do every day.

A graduate of Washington University Medical School, Dr. Sowa has practiced in Evansville since 1970, specializing in pediatric ophthalmology and strabismus. When she's not seeing patients, she fills her time with many outside interests, ranging from singing to sewing, or medically related volunteer work.

Although she is now learning to say "no" more often when she's asked to volunteer, she did not always feel that way. When she was asked to run for the Newburgh Town Board, she could not refuse; it was her civic duty, she says. She won the election, serving from 1980 to 1984, including a year as president. The town board seat involved serving a stint as street commissioner and as fire commissioner.

During her term on the town board, she also was persuaded to run for state representative on the Republican ticket. Although she lost, she has no regrets. Serving in the Indiana General Assembly would have meant sacrificing time from her practice and her patients.

Dr. Sowa – "Betsy" to friends – no longer lives in Newburgh.

Six years ago, she and her husband, Ronald, an orthopaedic surgeon, moved from their 150-year-old home to a new house on a heavily wooded lot on the west side of Evansville, where there's ample space for the couple's hobbies.

A deck stretching the width of the house accommodates her assortment of potted herbs. Her knowledge of herbs has made her a favorite speaker at the Newburgh Country Store Herb Festival, where her talk and demonstrations on using herbs in low-salt and low-cholesterol cooking are a regular part of the program. She has been speaking at the festival, held annually in April and publicized in national magazines, for the past 10 years. Her interest in low-salt and low-cholesterol diets stems from her need to

monitor her own sodium and cholesterol intake.

Dr. Sowa cultivates herbs not only for their culinary uses but also for their decorative and olfactory benefits. She combines dried herbs to create a fragrant pot-pourri bowl for the kitchen.

The home's lower level provides a room for another hobby, sewing. She makes many of her clothes, including a red ultrasuede coat that is one of her favorite creations, and also sews for her grandchildren.

Her artistic talents extend to craft projects, including the dried flowers, wreaths and needlework that decorate the house. She recently involved two grandchildren, visiting from California, in a T-shirt painting project.

The spacious house also offers adequate areas for Dr. Sowa to highlight her collections of objects ranging from butter dishes to washboards to antique kitchen gadgets. Started by Dr. Sowa's mother, the butter dish collection is displayed in specially designed cases along the dining room walls. Dr. Sowa continues to add to the collection.

Antique furniture, including a 100-year-old corner china cupboard that holds her mother's collection of decorated eggs, is another interest. The history of the pieces also fascinates her. For example, a drop-leaf accent table in the living room was once part of a larger table, which was eventually split between Dr. Sowa and a sister. Since additional legs were needed for the divided tables, Dr. Sowa's grandfather searched the fields until he found

Elizabeth Sowa, M.D.

I like being a physician because: It's fun, useful, helpful, interesting, never dull.

If I weren't a physician, I would be: I can't imagine what I'd have enjoyed more. I was a medical technologist for four years between undergraduate and medical school.

I relieve stress by: Music, sewing (sometimes), reading murder mysteries or biographies. □

cherry fence posts suitable for such a purpose.

A "non-professional musician," she enjoys singing in choirs. She's sung in church choirs and for 20 years was a member of the now-defunct Musicians Club Chorus that performed show tunes and in dinner theaters. She is a charter member of the Evansville Choral Artists, who present Christmas and spring concerts in the Evansville area. She prefers classical music for listening pleasure.

When it comes to dancing music, however, she and her husband are ready for a hoedown. The couple are square dancers and members of the Vagabond Squares, a group that travels out-of-town one weekend a month to dos-a-dos.

Dr. Sowa's other travels have taken her to more exotic destinations. She once went on an ar-



Dr. Sowa's creative talents are reflected in the ultrasuede coat she models and the floral grapevine wreath that decorates the front door of her Evansville home.

chaeological dig in the Cook Islands. She has seen the sights of Kenya, China, Russia, Japan and several European countries, including England, Germany and Poland, and often visits California to see her three children and her grandchildren. Despite the six to eight weeks a year she travels, her wanderlust is not satisfied; she says she longs to see New Zealand, South America, Australia and Alaska.

She also finds time in a busy schedule for volunteer work. She performs free school clinic eye

examinations and has served as a board member of the Evansville Association for the Blind, Southwest Indiana Public Broadcasting and ARK Crisis Nursery. She has also been active in the Vanderburgh County Medical Society and the Indiana State Medical Association.

How does she manage to compress so many activities into her life? "I just do what I like to do - or what I think I ought to do sometimes. There are certain responsibilities that go with life," she says. □



This embroidered work stitched by Dr. Sowa serves as a reminder of the United States bicentennial.



Dr. Sowa tends to the pots of herbs that she uses in cooking and to create potpourri.

Women in Medicine

fact sheet

- The number of women in medicine in the United States has grown dramatically. In 1970, there were 25,401 female physicians out of a total of 334,028. By 1990, the number of female physicians had increased to 104,194 out of a total of 615,421, or more than a 300% increase. By the year 2010, 30% of all physicians will be women, compared to 16.9% in 1990.
- In the 1990-91 year, women comprised almost 38% of students enrolled in U.S. medical schools, compared to only 9% 20 years earlier.
- As listed in the 1991 *Journal of the American Medical Association* medical education issue, approximately 24,500 female resident physicians, 29.5% of all residents, were on duty as of September 1990. More than one-third of women residents were training in internal medicine or pediatrics. Another 26% were in obstetrics/gynecology, family practice or psychiatry.
- In 1970, only seven specialties had more than 1,000 physicians. By 1990, 15 specialties had more than 1,000 women physicians. The same seven specialties with the most women in 1970 were the ones with the most in 1990 also. They are, in descending order,

internal medicine, pediatrics, general practice, psychiatry, obstetrics/gynecology, anesthesiology and pathology. In 1990, these specialties represented 67% of the total female physician population. Women are about three times as likely as men to be pediatricians and less than half as likely to be in general surgery or a surgical subspecialty.

- Between 1970 and 1990, women physicians in patient care increased by more than 100%, which was largely accounted for by the high increase of women physicians in office-based practice (13.9%). In 1990, 46% of all women were in office-based practice.
- In 1988, 9.9% of physicians practicing in non-metropolitan counties were women.
- In academic medicine, the percentage of women medical school graduates joining medical school faculties has been consistently higher than that of men. However, in 1991, although 21% of full-time faculty were women, only 9% were professors, and there were no female medical school deans.
- Female physicians are younger, on average, than male physicians. In 1990, almost 72% of female physicians were under age 45, with

the largest percent (37%) under age 35.

- Female physicians work about 10% fewer hours per year than male physicians and they spend about five to six fewer hours per week on practice activities. Their average number of total weekly patient visits is also lower – in 1990, 133 for male physicians and 100 for women.
- Female physicians remain less likely to be self-employed than male physicians and are twice as likely to be employees. In general, female physicians earn from 59% to 63% of the male mean annual net income amount, although the growth rate for females since 1981 has been higher. Contributing factors in the lower incomes for women physicians are that women are over-represented in the lower-paid specialties, are more often in salaried positions, work fewer hours, see fewer patients and are younger.
- Data from the AMA Socioeconomic Monitoring System core surveys for 1987-89 show that, among female physicians currently or previously married, 84.6% have children. □

Source: *The American Medical Association.*



To Plan The Most Successful Conference Possible, You Really Should Check All Your Options.

The University Place Conference Center & Hotel offers all the options you should expect to make your conference a success. And, probably a few things you'd never expect. So, if you'd like a free information packet on the features listed, call **800-627-2700**. Because once you've checked us out, you won't even consider any other location as an option.



University Place

Conference Center & Hotel

On the Campus of Indiana University • Purdue University
I N D I A N A P O L I S

800-627-2700

(In Indiana 317-274-3196)

Features	<i>University Place</i>
278-room AAA 4-Diamond hotel	✓
Resources of two major universities	✓
338-seat auditorium with sloped seating	✓
Unmatched A/V capabilities	✓
Award-winning restaurants	✓
385-car underground garage	✓
Full-time A/V staff	✓
Turnkey Conference Planning Service	✓
Skywalk to Olympic-class sports facilities	✓
Thirty soundproof meeting rooms	✓
Two tiered meeting rooms	✓
Videoconferencing	✓
Computerized audience response system	✓
Continuous refreshment service	✓

Indiana State Medical Association

1992 Annual Convention & Exposition

Friday, Oct. 16
Saturday, Oct. 17
Sunday, Oct. 18

Westin Hotel
Indianapolis

- * House of Delegates
- * Reference Committees
- * Risk Management Seminar
- * IMPAC Luncheon
- * President's Night Dinner and Entertainment

Abridged schedule of convention events

Thursday, Oct. 15

2:30 - 4:30 p.m. Board of Trustees meeting
6 - 7 p.m. Board of Trustees reception
7 - 9 p.m. Board of Trustees dinner

Friday, Oct. 16

9 a.m. - noon House of Delegates, first session
11 a.m. - 7 p.m. Exhibit hours
11 a.m. - 2 p.m. Luncheon in exhibit hall
Noon - 1 p.m. Past president's luncheon
Noon - 2 p.m. Spouse luncheon and program
1 - 6 p.m. Reference committees
5 - 7 p.m. Reception in exhibit hall
8 - 9 p.m. 7th District Afterglow
9 - 10 p.m. 12th District Afterglow

Saturday, Oct. 17

7 a.m. - noon Section meetings
8 - 10 a.m. "Preferred Risk" loss prevention seminar
10 a.m. - noon Medicare update
Noon - 2 p.m. IMPAC luncheon
6 - 10 p.m. President's Night Reception and Dinner
10 - 11 p.m. 1st District Afterglow
11 p.m. - midnight 10th District Afterglow

Sunday, Oct. 18

9 a.m. - noon House of Delegates, final session
Noon - 1:30 p.m. Trustees organizational and executive committee meeting □

Official call

The House of Delegates of the Indiana State Medical Association will convene at 9 a.m., EST Friday, Oct. 16, 1992, in Grand Ballroom 5 of the Westin Hotel in Indianapolis.

The House will reconvene for its second (final) session at 9 a.m. EST, Sunday, Oct. 18, in Grand Ballroom 5.

Representation in the House for the 1992 annual meeting will be as follows:

Indianapolis - 38 delegates
Lake County - 14 delegates
Allen County - 11 delegates
Vanderburgh County - 9 delegates
St. Joseph County - 7 delegates
Delaware-Blackford counties and Vigo-Parke-Vermillion counties - 5 delegates each

Owen-Monroe counties and Tippecanoe counties - 4 delegates each

Bartholomew-Brown, Elkhart, Madison, Porter and Wayne-Union counties - 3 delegates each

Clark, Daviess-Martin, Dearborn-Ohio, Fayette-Franklin, Floyd, Fountain-Warren, Grant, Harrison-Crawford, Howard, Jasper-Newton, Jefferson-Switzerland, LaPorte and Shelby-Rush counties - 2 delegates each

The remaining 49 Indiana county medical societies - 1 delegate each

Trustees - 15
Past presidents - 17
Resident Medical Society - 3 delegates
Student Medical Society - 4 delegates

Total delegates - 226. □

Program to focus on Alzheimer's disease

"Alzheimer's Disease: Research, Programs and Services" will be the focus of a program to be presented from 10 a.m. to noon Saturday, Oct. 17. The workshop will include presentations to complement physician's care of Alzheimer's patients and their families.

Sponsors of the program are the Aging/In-Home Services Unit of the Division of Aging and Rehabilitative Services and the Governor's Task Force on Alzheimer's Disease and Related Senile Dementia, in cooperation with the ISMA.

For more information, call the Aging and Home Services Unit at 1-800-545-7763, ext. 7020, or (317) 232-7020. □

Texas physician to conduct risk management seminar



Dr. Walker

Physicians will receive advice on how practicing effective medical management can help them reduce their exposure and insurance costs during a risk management seminar sponsored by Physicians Insurance Company of Indiana (PICI). The program, "From Exam Room to Courtroom," will be held from 8 to 10 a.m. Saturday, Oct. 17.

Richard W. Walker, M.D., an obstetrician/gynecologist from Clear Lake, Tex., will present the program. He is founder and president of Elenchos-Rimar Corp., national consultants in medical risk management, and has conducted risk management seminars for more than 2,000 physicians across the country. He also is founder and president of Natural Birthing Centers of America, a noted author and a medical school professor. A graduate of the Albert Einstein College of Medicine in New York City, Dr. Walker is a member of the Texas Medical Association.

He has written for publications including *Texas Medicine* and the *Texas Health Law Reporter*.

PICI has designated this seminar as a continuing medical education activity for two credit hours in Category I of the Physicians Recognition Award of the AMA. This program has been reviewed and is acceptable for two prescribed hours by the American Academy of Family Physicians.

The seminar is for physicians only. Advance registration is \$40 and must be received by Sept. 25. Registration at the door will be \$45. □

President's Night to honor outgoing ISMA leader

Outgoing ISMA president C. Dyke Egnatz, M.D., Schererville, will be honored as part of the annual President's Night reception and dinner Saturday, Oct. 17.

The evening will begin with a formal reception in the foyer outside the Capitol Ballroom from 6 to 7 p.m. sponsored by the Indiana Heart Institute. Dinner and entertainment, sponsored by Physicians Insurance Company of Indiana and Medical Accounts Group, will follow from 7 to 10 p.m. in the Capitol Ballroom.

Five Easy Pieces, whose repertoire ranges from swing to the most current dance hits, will provide the entertainment. The group, which includes two of its original members, is celebrating its 20th anniversary this year. It performs at such events as corporate functions, private parties, weddings and county fairs and has entertained at the Indianapolis 500 Festival and the Pan-Am games.

William H. Beeson, M.D., Indianapolis, will be installed as ISMA president during the dinner. □

'Family in Crisis' topic of spouse program

The ISMA Auxiliary will sponsor a program for spouses, titled "The American Family in Crisis: Some Solutions for the '90s," during the annual convention. The program will begin at 1 p.m. Friday, Oct. 16, following a noon luncheon.

James R. Davis, M.D., an Indianapolis psychiatrist, will speak. He is a national regional spokesman on dependency and issues of adult children from dysfunctional families. Dr. Davis is an assistant professor of clinical psychiatry at the IU School of Medicine and medical director of psychiatric services for Community Hospitals Indianapolis.

The cost of the luncheon is \$15. Registration and payment must be received by Sept. 25. □

Newspaper columnist to speak at annual IMPAC luncheon



Cal Thomas

Cal Thomas, a nationally syndicated newspaper columnist, will speak at the convention's annual IMPAC luncheon, set for noon to 2

p.m. Saturday, Oct. 17. He is expected to express his opinions on the presidential election and the impact of health care reform on the election agenda.

Whether speaking or debat-

ing on censorship, ethics, domestic or foreign politics and policies, Thomas offers a conservative perspective with skill and style. He writes a twice-weekly newspaper column distributed to more than 120 papers, including *The Indianapolis Star*, *The Boston Globe*, *The New York Daily News*, *The Miami Herald*, *The Denver Post* and *The Los Angeles Times*.

He contributes commentary to Channel 5's "Ten O'Clock News" in Washington, D.C. For two years he was the only conservative regularly contributing commentary to National Public

Radio's "All Things Considered." He also has guest hosted CNN's "Crossfire" and has appeared on "Donahue," "Nightline," "Good Morning America," "CBS This Morning" and "Today."

Thomas, a broadcast and print journalist for 29 years, has won numerous reporting awards. He has written seven books, the latest of which is *The Death of Ethics in America*. He is a graduate of American University in Washington, D.C.

Luncheon tickets are \$15 in advance or \$18 at the door. □

Commercial exhibitors of the 1992 ISMA annual convention

Computer companies

Advanced Medical Information Systems
Medical Accounts Group
RANAC Computer Corp.

Consulting companies

Crowe Chizek
Kimmerling, Myers & Co.
Practice Assessment

Financial institutions

Ent & Imler CPA Group
The Principal Financial Group
Whipple & Co., P.C.

Governmental agencies

U.S. Army Medical Department
U.S. Navy

Insurance companies

Anthem Health Systems
Fringe Benefit Planners
Medical Protective Company
P.I.E. Mutual Insurance Company

Physicians Insurance Company of Indiana

Laboratory services

Boehringer Mannheim Corp.
The Medical Laboratory
Pathologists Associated

Office management

Integrated Business Solutions
MedMate Medical Office Management Systems

Pharmaceutical companies

Allen & Hanburys, Division of Glaxo Inc.
Eli Lilly & Co./Dista Products Co.
Summit Pharmaceuticals

Miscellaneous

Arnett Clinic
Arthritis Foundation, Indiana Chapter
Charter Hospital of Indiana
GTE Mobilnet
Healthsource Indiana
Indiana Bell Ameritech
Indiana Medical Review Organization □

PICI booth to aid Physician Assistance program

Members of the Indiana State Medical Association who visit the Physicians Insurance Company of Indiana (PICI) exhibit at the annual convention will not only receive information on

Indiana's medical professional liability environment – they also will provide a financial benefit to one of ISMA's programs.

For each member who registers at the PICI booth, PICI will contribute \$5 to the Physician

Assistance Program, which aids impaired physicians and their families.

The exhibit will be open from 11 a.m. to 7 p.m. Friday, Oct. 16. □

ISMA to offer Medicare seminar

The latest information on Medicare, the Occupational Safety and Health Administration regulations on bloodborne pathogens and the Clinical Laboratory Improvement Amendments regulations will be presented at the

convention's Medicare update seminar.

Barbara Walker, ISMA reimbursement coordinator, will conduct the seminar from 10 a.m. to noon Saturday, Oct. 17.

There is no charge for this program. □

Specialty group meetings scheduled during convention

Two specialty groups will hold meetings in conjunction with the ISMA convention.

The Association of Indiana Directors of Medical Education will hold its annual meeting Friday, Oct. 16, at the Westin Hotel. The meeting, lunch and program will begin at noon and end at 2 p.m.

James M. Moorefield, M.D., chairman of the Board of Chancellors of the American College of Radiology, will be the guest speaker at the semi-annual meeting of the Indiana Roentgen Society. The group will meet from 8 a.m. to noon Saturday, Oct. 17, at the Westin Hotel. The executive meeting will begin at 8 a.m., and the general business meeting will start at 9:30 a.m. Dr. Moorefield will speak after the business meeting. □

ISMA trustee districts





C. Dyke Egnatz, M.D., president
Indiana State Medical Association
1991-92

Presidents of ISMA since its organization

Medical Convention

* Livingston Dunlap, Indianapolis

Elected 1849 Served 1849

Medical Society

	Elected	Served
* William T.S. Cornett, Versailles ..	1849	1850
* Ashahel Clapp, New Albany	1850	1851
* George W. Mears, Indianapolis	1851	1852
* Jeremiah H. Brower, Lawrenceburg ..	1852	1853
* Elizur H. Deming, Lafayette	1853	1854
* Madison J. Bray, Evansville	1854	1855
* William Lomax, Marion	1855	1856
* Daniel Meeker, LaPorte	1856	1857
* Talbot Bullard, Indianapolis	1857	1858
* Nathan Johnson, Cambridge City	1858	1859
* David Hutchinson, Mooresville	1859	1860
* Benjamin S. Woodworth, Fort Wayne ..	1860	1861
* Theophilus Parvin, Indianapolis	1861	1862
* James F. Hibberd, Richmond	1862	1863
* John Sloan, New Albany	1863	1864
* John Moffett (acting), Rushville	1863	1864
* Samuel L. Linton, Columbus	1864	-
* Wilson Lockhart (acting), Danville	1864	1865
* Myron H. Harding, Lawrenceburg	1865	1866
* Vierling Kersey, Richmond	1866	1867
* John S. Bobbs, Indianapolis	1867	1868
* Nathaniel Field, Jeffersonville	1868	1869
* George Sutton, Aurora	1869	1870
* Robert N. Todd, Indianapolis	1870	1871
* Henry P. Ayres, Fort Wayne	1871	1872
* Joel Pennington, Milton	1872	1873
* Isaac Casselberry, Evansville	1873	-
* Wilson Hobbs (acting), Knightstown ..	1873	1874
* Richard E. Houghton, Richmond	1874	1875
* John H. Helm, Peru	1875	1876
* Samuel S. Boyd, Dublin	1876	1877
* Luther D. Waterman, Indianapolis	1877	1878
* Louis Humphreys, South Bend	1878	-
* Benjamin Newland (acting), Bedford (v.p.)	1878	1879
* Jacob R. Weist, Richmond	1879	1880
* Thomas B. Harvey, Indianapolis	1880	1881
* Marshall Sexton, Rushville	1881	1882
* William H. Bell, Logansport	1882	1883
* Samuel E. Mumford, Princeton	1883	1884
* James H. Woodburn, Indianapolis	1884	1885
* James S. Gregg, Fort Wayne	1885	1886
* Gen. W. H. Kemper, Muncie	1886	1887
* Samuel H. Charlton, Seymour	1887	1888
* William H. Wishard, Indianapolis	1888	1889
* James D. Gatch, Lawrenceburg	1889	1890
* Consolvo C. Smythe, Greencastle	1890	1891
* Edwin Walker, Evansville	1891	1892
* George F. Beasley, Lafayette	1892	1893
* Charles A. Daugherty, South Bend	1893	1894
* Elijah S. Elder, Indianapolis	1894	-
* Charles S. Bond (acting), Indianapolis ..	1894	1895
* Miles F. Porter, Fort Wayne	1895	1896
* James H. Ford, Wabash	1896	1897
* William N. Wishard, Indianapolis	1897	1898
* John C. Sexton, Rushville	1898	1899
* Walker Schell, Terre Haute	1899	1900
* George W. McCaskey, Fort Wayne	1900	1901
* Alambert W. Brayton, Indianapolis	1901	1902
* John B. Berteling, South Bend	1902	1903
* Jonas Stewart, Anderson	1903	1904
* George T. MacCoy, Columbus	1904	1905
* George H. Grant, Richmond	1905	1906
* George J. Cook, Indianapolis	1906	1907
* David C. Peyton, Jeffersonville	1907	1908
* George D. Kahlo, French Lick	1908	1909
* Thomas C. Kennedy, Shelbyville	1909	1910
* Frederick C. Heath, Indianapolis	1910	1911
* William F. Howat, Hammond	1911	1912
* A. C. Kimberlin, Indianapolis	1912	1913
* John P. Salb, Jasper	1913	1914
* Frank B. Wynn, Indianapolis	1914	1915
* George F. Keiper, Lafayette	1915	1916
* John H. Oliver, Indianapolis	1916	1917

* Joseph Rilus Eastman, Indianapolis ..	1917	1918
* William H. Stemm, North Vernon	1918	1919
* Charles H. McCully, Logansport	1919	1920
* David Ross, Indianapolis	1920	1921
* William R. Davidson, Evansville	1921	1922
* Charles H. Good, Huntington	1922	1923
* Samuel E. Earp, Indianapolis	1923	1924
* Eldridge M. Shanklin, Hammond	1924	1925

Medical Association

	Elected	Served
* Charles N. Combs, Terre Haute ..	1925	1926
* Frank W. Cregor, Indianapolis	1926	1927
* George R. Daniels, Marion	1926	1928
* Charles E. Gillespie, Seymour	1927	1929
* Angus C. McDonald, Warsaw	1928	1930
* Alois B. Graham, Indianapolis	1929	1931
* Franklin S. Crockett, Lafayette	1930	1932
* Joseph H. Weinstein, Terre Haute ..	1931	1933
* Everett E. Padgett, Indianapolis	1932	1934
* Walter J. Leach, New Albany	1933	1935
* Roscoe L. Sensenich, South Bend	1934	1936
* Edmund D. Clark, Indianapolis	1935	1937
* Herman M. Baker, Evansville	1936	1938
* Edmund M. Van Buskirk, Fort Wayne ..	1937	1939
* Karl R. Ruddell, Indianapolis	1938	1940
* Albert M. Mitchell, Terre Haute	1939	1941
* Maynard A. Austin, Anderson	1940	1942
* Carl H. McCaskey, Indianapolis	1941	1943
* Jacob T. Oliphant, Farmersburg	1942	1944
* Nelson K. Forster, Hammond	1943	1945
* Jesse E. Ferrell, Fortville	1944	1946
* Floyd T. Romberger, Lafayette	1945	1947
* Cleon A. Nafe, Indianapolis	1946	1948
* Augustus P. Hauss, New Albany	1947	1949
* C. S. Black, Warren	1948	1950
* Alfred Ellison, South Bend	1949	1951
* J. William Wright, Indianapolis	1950	1952
* Paul D. Crimm, Evansville	1951	1953
* William Harry Howard, Hammond	1952	1954
* Walter L. Porteus, Franklin	1953	1955
* Walter U. Kennedy, New Castle	1954	1956
* Elton R. Clarke, Kokomo	1955	1957
* M. C. Topping, Terre Haute	1956	1958
* Kenneth L. Olson, South Bend	1957	1959
* Earl W. Mericle, Indianapolis	1958	1960
* Guy A. Owsley, Hartford City	1959	1961
* Harry R. Stimson, Gary	1960	1962
* Maurice E. Glock, Fort Wayne	1961	1963
* Donald E. Wood, Indianapolis	1962	1964
* Joseph M. Black, Seymour	1963	1965
* Kenneth O. Neumann, Lafayette	1964	1966
* Eugene S. Rifner, Van Buren	1965	1967
* G. O. Larson, LaPorte	1966	1968
* Patrick J. V. Corcoran, Evansville	1967	1969
* Lowell H. Steen, Hammond	1968	1970
* Malcolm O. Scamahorn, Pittsboro	1969	1971
* Peter R. Petrich, Attica	1970	1972
* James H. Gosman, Indianapolis	1971	1973
* Joe Dukes, Dugger	1972	1974
* Gilbert M. Wilhelmus, Evansville	1973	1975
* Vincent J. Santare, Munster	1974	1976
* John W. Beeler, Indianapolis	1975	1977
* Eli Goodman, Charlestown	1976	1978
* James A. Harshman, Kokomo	1977	1978
* Arvine G. Poppewell, Indianapolis	1978	1979-80
* Alvin J. Haley, Carmel	1979	1981
* Martin J. O'Neill, Valparaiso	1980	1982
* John A. Knote, Lafayette	1981	1983
* George T. Lukemeyer, Indianapolis	1982	1984
* Lawrence E. Allen, Anderson	1983	1985
* Paul Siebenmorgen, Terre Haute	1984	1986
* Shirley Thompson Khalouf, Marion	1985	1987
* John D. MacDougall, Beech Grove	1986	1988
* Fred W. Dahling, New Haven	1987	1989
* George H. Rawls, Indianapolis	1988	1990
* Michael O. Mellinger, LaGrange	1989	1991
* C. Dyke Egnatz, Schererville	1990	1992

* Deceased

■ annual reports

Editor's note: The annual reports that were not submitted in time to be included in this issue will be printed in the January 1993 issue of INDIANA MEDICINE.

EXECUTIVE COMMITTEE

C. Dyke Egnatz, M.D., chairman

The debate has begun on the soon-to-be-released report of the State Health Policy Commission. A presentation on the report at the July 15 executive committee meeting raised several concerns among executive committee members. Briefly, the draft recommendations call for: 1) global budgets to cap expenditures; 2) clinical panels to evaluate practice parameters and implement standards of practice; 3) primary health care teams, managed by a primary care physician; 4) a phase-out of fee-for-service medicine; 5) a separate critical illness system with critical care teams that practice in a network of "centers for excellence"; and 6) a non-profit licensing corporation composed mostly of consumer members and responsible for receiving complaints, investigations, and sanctioning health care workers.

The presentation left a number of unanswered questions: what will this new system cost and how will those costs compare with current health care costs? How many staff members will be needed to administer this system? Will physicians who follow guidelines indicated by the clinical panels be protected from malpractice suits? Is there an appeals process to resolve disagreements about clinical panel guidelines? Where will funding come from for critical care?

Since July, the executive committee and the board have made the ISMA's concerns known and

have suggested alternatives. With the final Health Policy Commission report due Nov. 1, and because of its potential impact on ISMA members, executive committee members suggested that a program on the report be presented to delegates at the annual meeting.

Continued developments on the Indiana Compensation Act for Patients (INCAP) prompted the executive committee to invite Indiana Insurance Commissioner Jack Mortel to speak at the April meeting. He presented a status report of the Patient's Compensation Fund (PCF). Mortel told the executive committee that the underlying coverage should be raised from \$100,000 to \$200,000 or \$250,000; that the surcharge on insurance premiums should be indexed; and that the PCF should be permitted to buy reinsurance. None of these recommendations was suggested by the insurance commissioner to the Interim Study Committee on Insurance Issues, however.

As the executive committee strives to be aware of ISMA members' needs, it continues to realize the importance of managing dues dollars to best meet those needs.

The resignation of the association's meeting planner provided an opportunity to compare costs of convention planning in house with the costs of contracting with an outside firm. Research indicated that the latter would provide considerable savings. In February, the association contracted with the Wiersma Company of Indianapolis to plan and market the convention.

A decision by Lincoln National to withdraw from the large client group health insurance market prompted the ISMA to seek a new health insurer for members.

After much study, the Subcommittee on Insurance recommended Acordia (Blue Cross/Blue Shield). The executive committee accepted the proposal effective July 1.

The executive committee endorsed the plan for the ISMA to participate in an AMA pilot project, the Practice Assessment/Quality Improvement (PA/QI) program. This risk management education program for primary care physicians is designed to reduce exposure to professional liability claims in the medical office setting. It allows physicians to compare their office practices with colleagues in their medical specialty.

Concerning Medicaid, continuing problems with the carrier prompted the executive committee to approve establishing a Medicaid ISMA Coalition similar to the ISMA Medicare Coalition. Both coalitions will be chaired by Timothy Brown, M.D.

The executive committee approved a request from Physicians Insurance Company of Indiana to enter discussions with Kentucky Medical Insurance Company and Physicians Insurance Company of Ohio regarding a merger of the three companies. At this writing, discussions continue.

BOARD OF TRUSTEES

Peter L. Winters, M.D., chairman

This year of rampant change in the medical profession required the Indiana State Medical Association Board of Trustees to respond on several fronts.

The Indiana Compensation Act for Patients (INCAP) and the final report of the State Health Policy Commission are two primary concerns for the ISMA.

Medicare payment reform, Occupational Safety and Health Administration (OSHA) regulations on bloodborne pathogens and the Clinical Laboratory Improvement Amendments (CLIA) also were high on the board's list of issues because of their impact on ISMA members.

INCAP

The ISMA continued its public and media education campaign on INCAP. In numerous editorial board visits and television and radio interviews, members of the board have discussed INCAP's goal to protect the health of the people of Indiana by protecting Hoosiers' access to quality health care. The features of INCAP, a Patient's Compensation Fund (PCF), a medical review panel and a \$750,000 limit on awards continue to address liability costs and the threat of impaired access to care. The message is that INCAP works.

ISMA representatives presented this same message to the Interim Study Commission on Insurance Issues that met during the summer to study the procedures of the act. On behalf of the board, I want to thank Michael Mellinger, M.D., immediate past president; William Beeson, M.D., president-elect; Jerome Melchior, M.D., second district trustee; Steve Sharp, M.D., ninth district trustee; Shirley Khalouf, M.D., past president; Tim Brown, M.D., assistant treasurer; Michael Herrell, M.D., Vanderburgh County president; and Al Cox, M.D., 13th district trustee, for the tremendous amount of time they have spent on the INCAP campaign. They are superb spokespeople.

Health Policy Commission

Fall 1992 marks the final year of a

three-year mission by the State Health Policy Commission to study Indiana's health care system and recommend changes. The final report is due Nov. 1. Initial drafts propose drastic changes in the way medical care is delivered in Indiana. It proposes expenditure targets, a global budgeting system, clinical review panels to study and distribute standards of care, primary health care teams, coordinated health care plans and restructuring of the medical licensing system.

In the 1991 House of Delegates, the Fifth District Medical Society introduced a resolution calling for the ISMA to establish a Commission on Medical Economics (Resolution 91-5). The board appointed an ad hoc task force, chaired by Michael Mellinger, M.D., to review that resolution. Because the State Health Policy Commission's report was forthcoming, and because of its anticipated impact, the ad hoc task force assumed the mission of reviewing the report and advising the board about alternatives.

Medicare Payment Reform

The ISMA's workshops on Medicare reimbursement reform assisted many physicians and their staffs in the transition to a new payment system. ISMA's Medicare reimbursement coordinators offered individual assistance to physicians and their staffs, as well. To assist doctors in explaining the changes to patients, the ISMA produced a new Medicare brochure entitled "What's Different About My Charges." This fall, the ISMA offered "Practice Management" for physicians and office managers, and "Medicare 101" workshops for new and experienced office personnel. The development of these programs

by in-house staff has met another goal of the ISMA to provide high-quality training to members.

OSHA, CLIA

OSHA regulations on bloodborne pathogens and the CLIA requirements presented additional challenges for physicians. To respond to ISMA members' needs, staff developed seminars on both OSHA and CLIA to help doctors implement the changes required. The association fielded numerous calls for assistance on these two issues.

In a year of so many regulatory changes, it has taken a massive effort by ISMA leadership and staff to continue to meet the needs of members. It has called for anticipation of events and interpretation of their impact and, at times, almost overnight response for printed materials and training. Richard King, executive director, and the ISMA staff are to be commended for their diligence and dedication.

AMA DELEGATION

Marvin E. Priddy, M.D.,
chairman

I would like to thank the members of our delegation for their dedication and effort in maintaining Indiana's active role at the AMA House of Delegates meetings:

Delegates

Alvin Haley, M.D., Indianapolis
John Knot, M.D., Lafayette
George Lukemeyer, M.D.,
Indianapolis
John MacDougall, M.D., Beech
Grove
Herbert Khalouf, M.D., Marion

■ annual reports

Alternates

Max Hoffman, M.D., Covington
George Rawls, M.D., Indianapolis
Shirley Khalouf, M.D., Marion
Ed Langston, M.D., Indianapolis
Mike Mellinger, M.D., LaGrange

Interim meeting

The AMA House of Delegates met Dec. 8 through 11, 1991, in Las Vegas with 442 credentialed delegates representing 54 states and territories, 81 national medical specialty societies, five special sections and five government services.

The delegates considered 90 reports and 214 resolutions. HIV testing for health care workers and the development of a national policy regarding the new Medicare payment system were two difficult issues that received the most attention from the delegates and the national press.

Because the Final Rule on the New Medicare Physician Payment System was issued in November and the carriers began sending the "Dear Doctor" letters Nov. 25, there was lengthy debate in the reference committee and on the floor of the House. The following are summary highlights of the policy statements adopted by the delegates:

1. The RBRVS-based Medicare physician payment schedule requires substantial improvements in many of its key elements; the AMA cannot endorse this new system until substantial improvements are made.
2. The AMA will analyze the implementation of the new Medicare payment schedule and take whatever steps are needed to correct and alleviate errors in the final schedule.
3. The AMA will expand its efforts to seek replacement of the current flawed proxy data basis for Medicare's geographic practice cost indexes (GPCIs) with current data that reflect actual practice overhead costs; the AMA will work to ensure that the professional liability component of both the GPCIs and the RBRVS more accurately reflects the actual cost experience of the physicians providing services to Medicare beneficiaries, including specialty-level differences in these costs.
4. The AMA will assign a continued high priority to legislative correction of grossly inequitable elements of Medicare physician payment policy as the lack of any payment for interpretation of EKGs, discriminatory payment reductions for new physicians, unfounded payment limits for the services of assistants-in-surgery, definition of new patients and the discriminatory 50% copayment for mental illnesses.
5. The AMA will seek adequate funding for Medicare carriers as they implement the RBRVS.
6. The AMA will work with the Health Care Financing Administration (HCFA) and the national medical specialty societies to clarify HCFA's new global payment policy and to disseminate accurate information to physicians on these policies.
7. The AMA Board of Trustees will study and report

to the House on the status and background of the "behavioral offset" and the "baseline adjustment" with an emphasis on the history of the use of these adjustments in Medicare Part B, including application to the RBRVS conversion factor and the MVPS.

In related actions, the House stated that the sole purpose of medical licensure is to assure the competence of physicians to practice medicine and voted to oppose any attempt to tie medical licensure to a physician's obligation to take part in any payment system or plan, including Medicare.

Other House action included adoption of resolutions related to:

- insurance company requests for patient information;
- student loan deferment;
- Medicare fee discrimination against new physicians;
- excessive cost of prescription drugs;
- nonalcoholic beer; and
- National Practitioner Data Bank.

Annual meeting

The 1992 Annual Meeting, June 21 through 25 in Chicago, was held with 436 voting delegates, 104 reports and 311 resolutions for consideration.

Major issues considered at the meeting included Medicare physician payment reform (RBRVS), confidential care for minors, self-referral, HIV infections and physicians, look-back program update, routine HIV testing, monitoring of HIV-infected physicians and review committee liability.

The House adopted the following policy statements for

AMA's future actions on RBRVS:

That the AMA take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including but not limited to:

- reduction of allowances for new physicians;
- the non-payment of EKG interpretations;
- defects in the GPCIs and area designations;
- inappropriate resource-based relative value units;
- the deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system;
- the need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality;
- the inadequacy of payment for services of assistant surgeons; and
- loss of a surgical tray benefit for many outpatient surgical procedures.

That the AMA seek an evaluation of: 1) stress factors as they affect the calculation of the Medicare payment schedule, seeking appropriate, reasonable and equitable adjustments; and 2) descriptors and other examples of services used to determine RBRVS values and payment levels and seek adjustments so the resulting values and payment levels appropriately pertain to the elderly and often infirm patients.

That the AMA evaluate the use of the RBRVS on the calculation of the work component of the Medicare payment schedule and ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value sys-

tem.

That the AMA seek to assure that all modifiers, including global descriptors, are well-publicized and include adequate descriptors.

That the AMA seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures and/or future procedures.

That the AMA take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs.

On the self-referral issue, a resolution from New Jersey was adopted, which stated:

That the AMA adopt the policy that medically necessary referrals by a physician to an off-site facility in which he/she has a financial interest is ethical if the patient is fully informed of the ownership interest and the existence of any available alternate facilities.

At the direction of the ISMA Board of Trustees, the Indiana delegation introduced a resolution dealing with CPT codes outpatient observation services. A substitute resolution was adopted by the AMA House of Delegates with the following language:

RESOLVED, That the AMA Board of Trustees request the CPT Editorial Panel to consider the development of separate codes for phy-

sicians' observation services; and be it further

RESOLVED, That the AMA work toward appropriate reimbursement for outpatient hospital-based observation services; and be it further

RESOLVED, That the AMA work aggressively to remove denials of payment based on a technical declaration of status.

The House elected Joseph Painter, M.D., president-elect; Daniel Johnson, Jr., M.D., speaker of the house; and Richard Corlin, M.D., as vice speaker. George Lukemeyer, M.D., was re-elected to his third term on the AMA Council on Medical Education. Indiana also continues to be represented on the AMA Council on Medical Service by John Knotte, M.D.

During the 1991 ISMA annual convention, a long-time dedicated member of our delegation, Peter Petrich, M.D., Attica, retired, and William VanNess II, M.D., Summitville, alternate delegate, chose not to run for re-election. John MacDougall, M.D., Beech Grove, was elected to fill the delegate position, and the ISMA House elected George Rawls, M.D., Indianapolis, and Mike Melinger, M.D., LaGrange, to fill the two alternate delegate vacancies. Their two-year terms began Jan. 1.

Thanks to Dr. Petrich and Dr. VanNess for their loyalty in representing Indiana in the AMA House of Delegates. With regret, the delegation accepted a letter of resignation from alternate delegate, Richard Reedy, M.D., Yorktown. His service on the delegation is appreciated and will be missed. A new replacement will be elected at the 1992 ISMA annual convention.

■ annual reports

The entire delegation works diligently at each AMA meeting to voice the "Indiana perspective" on vital issues affecting the Hoosier physician and the delivery of health care in the state. If you can't attend the meetings, you can still be assured that you are represented through your delegation. Let us know your opinions!

RESIDENT MEDICAL SOCIETY **Clint Myers, M.D., trustee**

The ISMA Resident Medical Society has completed another busy year. There have been an extraordinary number of legislative issues that directly affect residents. The ISMA-RMS has efficiently responded to local and national issues by writing letters, making telephone calls and educating our colleagues while enlisting their support.

Nationally, there has been a decline in resident membership in organized medicine. This trend also has been felt in Indiana. In an effort to boost membership, several steps are being taken. A recruitment letter informing new residents of important current legislation will be sent with an ISMA-RMS benefits package. Through more positive interaction with the Medical Student Society, we are seeing more students remain active through residency.

Mike Abrams, director of ISMA Government Relations, has offered to address resident groups and discuss medically related legislative issues. His presentations will heighten awareness of the importance of legislative participation in organized medicine.

Despite declining numbers, there are some unique qualities to the current ISMA-RMS delegation. They remain well-informed of

current issues and are very eager to act when necessary. The current delegation is comprised of representatives from five specialties. This diversity is one of the strengths of the ISMA-RMS.

I would like to thank the ISMA for its support of the RMS and commend the foresight of this organization for encouraging involvement early in a physician's career.

It has been a pleasure to serve the RMS this year. It has been a very rewarding opportunity. I would like to thank the members of the RMS for their participation and support. Best wishes in your future practices.

MEDICAL STUDENT SOCIETY **Paul Forman, trustee**

This has been a busy and productive year for the Medical Student Society (MSS). Membership has continued to increase, and participation in the AMA national meetings has helped us gain recognition as a political power. We consistently have taken 25 to 30 people to interim meetings and more than 30 people to annual meetings in the last several years. This is one of the most exciting, educational and worthwhile aspects of our program.

This year, the Indiana delegation was responsible for three resolutions and had members on several committees, including one reference committee. National meetings have become one of our best membership recruitment and retention tools because meeting events are exciting to newcomers. Four students also attended the Leadership Conference in Los Angeles, which was very educational.

The student society also has

been busy on the state level. Our participation in the ISMA, with four state delegates, a trustee and student members of many ISMA committees, has continued to benefit both the students and the committees.

The student society has concentrated on these activities:

1) Expanding the "Student-to-Student" program to the northwest and Bloomington campuses – This program, previously done only in Indianapolis, allows medical students to visit local schools and talk about smoking, drugs, alcohol, AIDS and other health-related subjects. These visits have been tremendously successful – we received more requests for visits than we were able to give.

2) Conducting letter writing campaigns for various legislative concerns – Most of our efforts focused on the national level on issues such as student loan deferment.

3) Supplying lab coats to the dean's office – Each year, the dean's office gives a lab coat to incoming first-year students. The MSS also sells lab coats to raise funds. So it became a natural relationship for the dean's office to not only get a higher quality coat for a cheaper price but also to support a student organization. We hope to continue this relationship for many years to come.

The MSS is planning bigger and better projects for next year. Some goals for the year include improving recruitment and increasing member participation, especially on the Indianapolis campus. A sectional meeting for Section 5 of the AMA-MSS also is planned.

Besides continuing current projects, we hope to expand the "Student-to-Student" project to other campuses, involve more

students and increase our state political work. The MSS also is organizing a telephone tree and, in cooperation with Mike Abrams, plans to increase our letter writing campaigns.

The MSS will strive to involve students in lobbying efforts, such as participating in "Medicine Day" at the statehouse and urging students to talk and write to their legislators. We have a great group of new people and plenty of ideas. I expect next year to be a record-setting year for accomplishments in the MSS.

PHYSICIANS INSURANCE COMPANY OF INDIANA **M. David Duncan, PICI** **president and CEO**

During 1992, activities of the Physicians Insurance Company of Indiana (PICI) have continued to reflect the delivery of high-quality professional liability coverage, our value-added supplemental and complementary services and our commitment to maintaining the stability of Indiana's medical malpractice environment.

With respect to value-added services, PICI is in its third consecutive year of providing risk management seminars for Indiana physicians and their medical staff members. Also, we were selected in concert with the ISMA to be one of six states for a pilot risk management program developed by the AMA/Specialty Society Medical Liability Project, called the Practice Assessment/Quality Improvement (PA/QI) program. You will hear more about this program in coming months.

PICI's special coverage programs for medical groups and corporations, called MedGroup, continues to be extremely well-

received. Our Young Physicians Program, designed for medical residents and physicians in their early years of practice, remains unmatched by any other insurer in Indiana.

A large number of PICI policyholders are accumulating significant annual premium savings through our Preferred Risk Program for participating in our risk management programs and remaining loss-free over a given period of time. Many Indiana physicians and non-surgical specialties enjoy the lower premiums of our Class 1-A risk classification.

Nationally, professional liability insurers and their policyholders are being confronted by two issues of major concern: 1) upward trends in claims frequency and severity; and 2) a disturbing outbreak of irresponsible, and sometimes fraudulent, marketing schemes.

The upward claims trends are attributable to the cyclical nature of all forms of insurance and the effects of a prolonged period of economic depression. Indiana's cap on medical malpractice awards enables our state to avoid the excessive payouts that occur in other states. But Indiana is not immune to the accelerating claim payment levels or rising frequency.

To help control the cost and incidence of claims in Indiana, PICI emphasizes strong opposition to unwarranted or questionable allegations of negligence; tough, experienced and professional legal defense services; and risk management education programs that focus on nonclinical and clinical facets of your medical practice.

It is becoming increasingly apparent that "predatory pricing" marketers are attracted to the

professional liability insurance market by the substantial premiums involved and the delayed nature of claims development. In recent months, insurance regulators in several states, including Illinois, West Virginia, Florida and Georgia, have taken formal actions to curtail the operations of specific sources of coverage and/or marketing organizations. Invariably, irresponsible or outright fraudulent sources feature large "premium savings" and cite an organizational, operating or service concept that supports their ability to underprice. Unfortunately, by the time the regulators obtain sufficient data to take action, some physicians or other health care practitioners already have purchased coverage that may prove to be highly suspect.

Indiana physicians have coverage options from well-established Indiana-based insurers. PICI urges Indiana physicians tempted by promises of substantial premium savings to carefully check the credentials, operating philosophies and long-term commitments of all sources of coverage.

We fully expect that special interest groups soon will attempt to achieve changes in Indiana's medical professional liability statutes. Clear indications of what we may expect surfaced at recent public hearings conducted by the Indiana legislature's Interim Study Committee on Insurance Issues. Predictably, a representative of the Indiana Trial Lawyers Association attacked various portions of the Indiana Compensation Act for Patients, enacted in 1975, with major criticism focusing on the cap on awards.

An out-of-state insurer that is actively soliciting Indiana physicians for medical malpractice cov-

■ annual reports

erage also appears to oppose the cap on awards. An attorney speaking on behalf of the company said it "supports the act as an equitable, fair act" but added that the insurer's "studies of the act show that there are inadequacies."

Other statements made by the attorney on behalf of the out-of-state insurer include: "Caps prohibit adequate compensation ... Consumers are affected because when higher awards are needed, they are unavailable." One additional statement was extremely significant: "Physicians should purchase umbrella policies that would cover limitless liability."

Presumably, this insurer would be willing to offer Indiana physicians insurance protection for the "limitless liability" it believes they should assume so consumers can receive higher awards. Its spokesperson did not comment on the many ramifications of limitless medical professional liability in our state, but did add that the umbrella policies "would not cost that much."

PCI will continue to join forces with the ISMA in opposing any actions that would be detrimental to the long-term best interests of Indiana physicians and patients, and the health care industry in our state. We believe Indiana physicians should remain interested in the positions and viewpoints of all those involved with our state's current professional liability statute.

PCI maintains its conviction that there is much more to high-quality professional liability insurance protection than the provision of contractual coverage in return for a premium charge. The types of short-term, opportunistic marketing concepts and operating philosophies that may be appli-

cable in more traditional lines of insurance do not adapt appropriately to the special characteristics of medical professional liability, and more specifically, to Indiana's medical malpractice law.

Comments, opinions and questions from all Indiana physicians are welcome. Call 1-800-284-7424 or write Physicians Insurance Company of Indiana, 8425 Woodfield Crossing Blvd., Suite 300, Indianapolis, IN 46240.

FIRST DISTRICT

Bruce Romick, M.D., trustee

As First District trustee, I am pleased to report on past and future activities of the ISMA.

I am proud that the First District is represented both on the Board of Trustees and the Executive Committee. John Bizal, M.D., had served two years as ISMA assistant treasurer when he was elected ISMA treasurer last year. My congratulations to John. This position may lead to even greater things and may permit the First District to congratulate John as ISMA president in the next few years. We hope and expect that Dr. Bizal's success is just a sign that southwestern Indiana intends to be a presence in the '90s with good leadership.

Lincoln National Life Insurance Co., the carrier for the ISMA-sponsored health insurance plan, has decided to divest itself of its health insurance plans. To fill the void, the ISMA has finalized the transfer of coverage to Acordia Health Industry Benefits. This change was effective July 1. Claims for services after July 1 should be sent to Acordia.

With the exception of a \$2 million lifetime cap on benefits, the plans offered and most rates

are identical to the Lincoln plan. No pre-existing period is required, and there is no underwriting. You should have received further information by mail, including new membership cards and claim forms.

The ISMA has been active in providing information and educational programs for physicians and their office staffs regarding changes in Medicare billing and coding brought about by RBRVS implementation. A pamphlet explaining levels of care and physician charges was developed by the ISMA. More than 10,000 were distributed in less than a week.

Looking toward the future, we have reason to expect 1993 will be a very important year for medical practice in Indiana. The agreement among the ISMA, the Indiana Hospital Association and the Indiana Trial Lawyers Association is due to expire in 1993. That agreement resulted in a negotiated increase in the cap from \$500,000 to \$750,000 in medical liability. We expect a major battle over the Indiana Compensation Act for Patients (INCAP).

First District physicians including Mike Herrell, Bill Skaggs and Joe Ruske have participated in ISMA spokesperson training and have been visiting editorial boards in Evansville, Bloomington and South Bend.

Sen. Dan Coats has introduced federal legislation to enact a national program similar to INCAP. It seems ironic that as we struggle to preserve INCAP in Indiana, a similar project is being introduced as a possible national solution to the professional liability problem.

With this and many other challenges on our horizon, your input is encouraged and solicited. As we speak, there are openings

on the Indiana Medical Political Action Committee. In addition, there are many ways physicians can make a difference in organized medicine and direct the changes coming in medical practice. After all, it is through our patients, the recipients and consumers of health care, that we have yet to exert our greatest influence.

If you have comments or questions or are interested in serving on a committee, please contact me or the ISMA offices.

SECOND DISTRICT

Jerome Melchior, M.D., trustee

It has been a privilege to represent the Second District for another year. However, this year has been one of the most frustrating since I've been involved in organized medicine.

With the introduction of the resource-based relative value scale, followed by the OSHA and CLIA regulations, those of us on the front lines have more and more problems rendering quality medical care to our patients. Each new regulation requires more time away from our primary goal - patient care. Hopefully, such adversity will bring us together to defend our patients' rights.

Our district meeting was held in Linton this year and was one of the best attended. I want to thank our alternate trustee, Jim Beck, M.D., of Washington for his help this year. A special thanks from the entire district goes to Janna Kosinski, our ISMA field representative. Janna is knowledgeable, interested and available to help with the multiple questions generated by all of the new federal regulations.

THIRD DISTRICT

Gordon Gutmann, M.D., trustee

The Third District held its annual meeting May 13 at the Lakeview Motel in Clarksville. We were fortunate to have Sen. Kathy Smith as our featured speaker. The presentation detailed the plans of the Health Policy Commission and, before it was over, there was extensive interchange between the audience and speaker. It was a unique experience that enlightened everyone.

There seems to be less interest in the state medical organization by the membership, no doubt due to the various initiatives of the federal government. The OSHA regulations, CLIA rules and resource-based relative value scale have taken the spotlight this year.

We are now witnessing the beginning of government control of all of our charges and reimbursements. The government has made promises they cannot keep and is making up for "no new taxes" by taking it from physicians and other health care providers.

Organized medicine has its work cut out for itself in the future.

FOURTH DISTRICT

Arthur C. Jay, M.D., trustee

The Fourth District held its annual meeting May 6 at the Harrison Lake Country Club. Only 17 physicians attended the meeting. However, the content of the meeting was excellent and included discussions regarding the medical malpractice issue, which might be an issue in the 1993 legislature. The next annual meeting will be May 5, 1993, in Batesville.

The most worrisome issues

are medical malpractice, Occupational Safety and Health Administration (OSHA) regulations and CLIA. Questions from the district included how the OSHA regulations will be implemented and enforced. Concerns on the CLIA issue include the complexity of the tests that are performed, necessary personnel and proficiency testing.

In addition, there have been problems with EDS and Medicaid related to paperwork and documentation and coding with prior authorization. The resource-based relative value scale is another concern.

Three quarterly meetings were well-attended and informative. These meetings promoted informative and helpful discussions among the county societies. The work and assistance of Janna Kosinski, ISMA field representative for the Fourth District, are extremely helpful and appreciated.

We also attended the Physicians Insurance Co. of Indiana's risk management meetings.

SIXTH DISTRICT

Ray Haas, M.D., trustee

The Sixth District held its annual meeting at Forest Hills Country Club in Richmond. Following a golf outing, a short business meeting was held with William Toedebusch, M.D., presiding. Howard Deitsch, M.D., was elected alternate trustee. ISMA representatives gave short presentations to update district members.

Before dinner, a stimulating discussion was presented by Ken Stella, president of the Indiana Hospital Association, on "Medicine in the '90s and How It Will

■ annual reports

Affect Doctors and Smaller Hospitals." This was a thought-provoking talk.

This year, physicians earned CME credit for attending the annual meeting. Another first this year included financial assistance from pharmaceutical companies in return for displaying exhibits.

Bob Sullivan, ISMA field representative, is to be commended for his outstanding work. His diligent attendance at county society meetings and visits to local hospitals helped keep members informed of ISMA and AMA concerns and provided a "sounding board" for physicians with problems.

Throughout the next year, Dr. Deitsch and I plan to attend many of the county society meetings to try to stimulate more participation from members and provide members with an opportunity to express their concerns to the ISMA.

SEVENTH DISTRICT

Donna Meade, M.D., Peter Winters, M.D., & John Records, M.D., trustees

We are pleased to report that the membership continues to increase at a good pace. We believe this speaks favorably for the steady progress our organization is making as physicians become more politically aware and more actively involved in their county and district medical societies.

Trustees lobby for district

Continuing in their roles on behalf of Seventh District physicians, our trustees visited Washington and met with several Congressmen and representatives. We again had members who served as "Physician of the Day" in the Indiana legislature. Many of our

members participated in the first "Doctor's Day" at the legislature and met with elected representatives.

Resignation

Charles McCormick, III, M.D., past president and alternate trustee, discontinued his district activities. While we are sorry to lose his leadership and participation, we accept his decision and appreciate his past service.

Highlights of the annual meeting

Several years ago, district leaders voted to structure our annual meetings for the entire family and meet at facilities conducive to a relaxing, enjoyable evening. Certainly, this year's meeting reaffirmed that good decision. Seventh District President, Bernard J. Emkes, M.D., welcomed physicians to this year's annual meeting at the Indianapolis Zoo, one of the best meetings in terms of attendance and family activities.

Back by popular demand was Carl ("That's me") Andrews who captivated the young and entertained the not-so-young with his unique combination of magic and comedy. Tim Arnold, a nationally renowned silhouettist, produced keepsake silhouettes for children and adults. The Melchior Marionettes entertained the younger children during the reception, and the evening ended with a dolphin show.

During the business meeting, several ISMA officers urged physicians to become politically involved to counteract the attack by the trial lawyers on the Indiana Compensation Act for Patients. Because this issue will directly affect all physicians in Indiana, district leaders will conduct an informational meeting during the 1992 ISMA convention.

Recognition to Drs. Meade, Trusler

During the meeting, Dr. Emkes expressed his appreciation to Donna J. Meade, M.D., who has served three terms as district trustee, and, therefore, was not eligible for re-election. Dr. Emkes also thanked H. Marshall (Sandy) Trusler, M.D., who chose not to run for re-election as treasurer.

District representation in ISMA leadership

We look forward to the coming year as William H. Beeson, M.D., assumes the office of ISMA president. We are confident that Dr. Beeson will provide the astute leadership required to ensure an optimistic future for physicians in Indiana. Additionally, Peter L. Winters, M.D., has skillfully served as chairman of the ISMA Board of Trustees this year, and we offer him our best wishes as he seeks the office of vice speaker of the ISMA House of Delegates.

Elections

The following officers were elected: Paula Hall, M.D., Morgan County, president-elect; Craig Moorman, M.D., Johnson County, treasurer; Ronald Blankenbaker, M.D., Indianapolis, trustee; Bernard Emkes, M.D., Indianapolis, alternate trustee; and Frank Johnson, M.D., Indianapolis, alternate trustee.

President Stegemoller

Following the annual meeting, Ronald Stegemoller, M.D., of Hendricks County began his term as president and will be diligently working for our members during his term of office.

Congratulations to all of our newly elected and re-elected officers, and "thank you" for your willingness to represent the mem-

bership of the Seventh District.

EIGHTH DISTRICT

John V. Osborne, M.D., trustee

During the 1991-1992 season, the Eighth District officers and officers of the various Eighth District components met at the Delaware Country Club and Anderson Country Club to plan the Eighth District Medical Meeting.

The Eighth District Medical Meeting was held June 6 at the Anderson Country Club. The meeting was preceded by a golf outing and followed by dinner and entertainment.

The meeting was called to order by Robert Helm, M.D., president of the Eighth District Society. The treasurer's report indicated a balance of \$7,646.62 as of June 1, 1992.

Gordon Hughes, M.D., of Muncie was elected president and Gerard Costello, M.D., was elected secretary. The trustee will continue as treasurer. The 1993 annual meeting will be held at the Delaware Country Club and hosted by the Delaware Blackford Medical Society.

Dr. Helm announced that William Van Ness, M.D., will run for ISMA president-elect. The Eighth District gives its full support to Dr. Van Ness.

The policy of allowing pharmaceutical and surgical equipment firms to display at the district meetings was discussed during the meeting. Since other districts allow these displays to help finance their meeting expenses, the policy was approved on a two-year trial basis. The officers will institute rules and regulations for this policy.

The following people gave county society reports: Dr.

Costello, Delaware Blackford; Kathleen Galbraith, M.D., Jay County; Dr. Helm, Madison County; and Susan Pyle, M.D., Randolph County. Dr. Helm pointed out that no action had been taken in Madison County's proposal to have a non-binding credentialing organization. He also said the insurance program for the "working poor" will be underwritten by Golden Rule Insurance and administered by First Benefit. The program should begin in September 1992.

Patient complaints against physicians also was discussed. The district decided that all complaints be made in writing before any action is taken. Any action taken will be decided by the individual society. Ron Dyer, ISMA legal counsel, can provide assistance.

The meeting ended with dinner and entertainment by barber-shop singers.

NINTH DISTRICT

Stephen Tharp, M.D., trustee

This year, the Ninth District was active in serving its members. The annual district meeting was held June 11 at the Curtis Creek Country Club in Rensselaer and was hosted by the Jasper/Newton County Medical Society, and Robert Darnaby, M.D., Ninth District president. The meeting gave many ISMA members, from within and outside of the Ninth District, an opportunity to discuss current trends in medicine.

We were pleased to hear from ISMA President, C. Dyke Egnatz, M.D., and President-elect William Beeson, M.D., both of whom stressed the importance of diligent monitoring and continued involvement in the politics of medi-

cine, particularly the many proposed changes that have surfaced in the past year.

Of particular concern to our members are the legislative changes in Minnesota, resulting in a tax on health care providers designed to support indigent care. In Indiana, the Indiana Health Policy Commission has made several recommendations that could drastically change the practice of medicine. Unfortunately, many of these changes may threaten the quality of patient care as well as the doctor/patient relationship. Clearly, it is up to us to help maintain a system where quality patient care remains our primary goal.

Other speakers at the annual meeting included John Knote, M.D., AMA delegate; Max Hoffman, M.D., AMA alternate delegate; and Richard King, ISMA executive director.

Many of our members have been active in promoting ISMA interests this year. In particular, Timothy Brown, M.D., ISMA assistant treasurer, and I have traveled throughout the state to discuss the Indiana Compensation Act for Patients with the media.

We hope that through our members we can remain active in protecting the needs of physicians and patients across the state, as well as in the Ninth District. We look forward to continuing that tradition.

TWELFTH DISTRICT

John Thomas, M.D., trustee

Presidents of the county medical societies in District 12 met in April and discussed the long-range plans for the annual district meeting. Last year, we changed the format to a golf outing, and at

■ annual reports

this meeting, we elected to continue that tradition.

Since the 12th District is made up of nine county medical societies, we also discussed moving the location of the meeting around the district to try to involve all of the societies in the annual meetings. We decided to hold this year's meeting in Auburn. The golf outing will be at the country club, and the meeting and dinner will be at the Auburn, Cord, Dusenberry Museum. A political speaker was scheduled to appear, but at the time of this writing, the speaker was not confirmed.

This past year, I have attended several county society meetings and discussed the concerns of the physicians in the 12th District. I find the main concerns in our area focus on the large number of very sick uninsured patients seeking care and on the need to find primary care physicians for rural, underserved regions of this district.

This has been a challenging and enjoyable year for me as trustee of the 12th District. My goal has been to represent all of the members of our district to the best of my abilities. If there are any questions from district members, I would enjoy the opportunity to discuss them.

THIRTEENTH DISTRICT

Alfred Cox, M.D., trustee

The 1991 13th District Medical Society Annual Meeting was hosted by the LaPorte County Medical Society at Pottawattomie Country Club, Michigan City. Mark Ballard, M.D., district president, presided at the afternoon business meeting and emceed the evening dinner entertainment by the Jeff Brown Trio from

Valparaiso.

I would like to thank Richard Houck, M.D., for his help and service as the alternate trustee for the 13th District and for the efforts of the current District President David Haines, M.D., of Warsaw.

COMMISSION ON CONSTITUTION & BYLAWS

Helen Czenkusch, M.D., chairman

Resolution 91-8, Timely Distribution of ISMA Resolutions to County Medical Societies, resolved that the bylaws be amended to require that the current deadline for submission of resolutions be extended to 60 days before the convening of the ISMA annual meeting. This makes Aug. 17, 1992, the deadline for submitting resolutions to the 1992 House of Delegates (i.e., 60 days before the convention).

Resolution 91-11, ISMA Commission on Medical Services, was discussed at the ISMA Board of Trustees meeting May 17, and the board approved its ad hoc committee's recommendation to dissolve the inactive Commission on Medical Services but to keep in place the active subcommission to be renamed the ad hoc Committee on Insurance.

ISMA staff and Chairman Helen Czenkusch, M.D., amended the appropriate sections. The 1992 House of Delegates handbook contains the ISMA Constitution and Bylaws and incorporates these amendments from the 1991 House of Delegates.

COMMISSION ON LEGISLATION

Eugene Roach, M.D., chairman

The 1992 session of the Indiana General Assembly was the shortest session in the state's history. Final adjournment occurred Feb. 14. Following the 1991 record-breaking long session, legislators were anxious to complete their business so they could return home and begin working on the upcoming elections. The quick adjournment schedule meant the session moved at a swift pace – bills either made the fast track toward passage or were left behind for discussion in another session. Consequently, less than 30% of introduced bills passed, meaning legislators successfully killed more bills than they passed.

Health care issues were the focus of many legislative proposals and a number of long debates. The following is a summary of a few of the new health care laws of interest to physicians:

HEA 1006 – Makes it unlawful to sell a human organ for use in human organ transplantation. Prohibits charging an organ donor for the costs related to an organ donation.

HEA 1146 – Makes changes to the small employer health insurance market to make it easier for small employers to purchase insurance.

HEA 1182 – Requires utilization review (UR) firms doing business in the state to be registered with the department of insurance. Requires the standards and criteria for review to be developed by a physician.

HEA 1337 – Establishes the drug utilization review board as required by federal guidelines.

SEA 391 – Requires the state employee's insurance program to

cover breast cancer diagnostic services, breast cancer outpatient treatment services and breast cancer rehabilitative services.

The list of bills below highlights some of the more important bills which did not become law during the 1992 session:

HB 1001 – Would have allowed patients to indicate in a living will that they would like to have nutrition and hydration withheld or withdrawn in the event that they become terminally ill or are in a persistent vegetative state.

HB 1023 – Would have provided for a universal health care system (i.e., socialized medicine) in Indiana, administered by the state government.

HB 1220 – Would have allowed the workers compensation board, which is comprised of attorneys, to implement a fee schedule for physician reimbursement for services performed under workers compensation.

HB 1222 – Would have prohibited physicians from charging for the first hour of consultation with a patient or a patient's attorney when the patient's health care is at issue in a legal proceeding.

HB 1366 – Would have increased the tax on cigarettes by \$.45 per pack.

HB 1395 – Would have allowed certification and title protection for the title "professional counselor."

HB 1399 – Would have allowed physicians to test patients for HIV with general health care consent, negating the need to obtain special, documented consent.

SB 198 – Would have provided for the licensure of athletic trainers.

SB 253 – Would have provided for the certification of hypnotists.

SB 277 – Would have provided for licensure of acupuncturists.

Due to the shortness of this past session, the Commission on Legislation only met two times to review pending legislative proposals and their impact on physicians in the state.

The ISMA staff has published the 1992 *Digest of Health and Medical Laws*, which highlights newly created health care laws of the state. To receive a copy, contact the ISMA Department of Government Relations at (317) 261-2060 or 1-800-257-ISMA.

COMMISSION ON MEDICAL EDUCATION

James E. Carter, M.D., chairman

The Commission on Medical Education and its Subcommittee on Accreditation each met Nov. 17, 1991, and April 26, 1992. Stephen Jay, M.D., is chairman of the Subcommittee on Accreditation, and Donald Dian, M.D., is vice chairman of the Subcommittee on Accreditation. Glenn Bingle, M.D., is vice chairman of the Commission on Medical Education and chairman of the Subcommittee on Physician Remedial Education.

This year, 12 institutions and organizations were approved by the Commission on Medical Education for reaccreditation. Two institutions and organizations were accredited for a two-year provisional accreditation. Two institutions and organizations were placed on two-year probationary reaccreditation.

The Commission on Medical Education and the Subcommittee on Accreditation have initiated a process of receiving annual reports from all 62 institutions and

organizations currently accredited by the state. This process has augmented accreditation procedures in the state for continuing medical education (CME). The fee for accreditation of institutions and organizations in Indiana has increased because of the rising costs of the accreditation process.

The Commission on Medical Education revised the ISMA Guidebook and Application for Accreditation of CME in Indiana.

The Commission on Medical Education and the Subcommittee on Accreditation will adapt revised standards for commercial support of CME to the ISMA CME accreditation standards. This is an important issue currently confronting the profession. It is important that Indiana organizations and institutions meet the new standards.

The Commission on Medical Education submitted an application for reaccreditation of the ISMA as an accreditor of intrastate providers of CME. The application review is conducted by the Accreditation Council for Continuing Medical Education. At the April commission meeting, surveyors from the Committee for Review and Recognition of State Medical Societies visited and surveyed our program. The survey discussions were informative. Questions were raised about the role of ISMA staff and the importance of sufficient staff support in a large statewide CME accreditation program such as Indiana's, the fifth largest program in the nation. Questions also were raised about the due process for appeals in the accreditation process. The Commission on Medical Education will be notified of the outcome in October.

Several issues concerning medical undergraduate education

■ annual reports

were presented to the commission. The commission discussed the decreasing career interest of medical students in primary care in the state and nation and considered support of activities that might have an impact on this interest. The third-year family medicine clerkship at the Indiana University School of Medicine was discussed briefly. This program has been in effect for one year and is well-received by students; it is hoped that this will increase the interest in family medicine. The Commission on Medical Education received a report on Gary's new problem-based learning program, which appears to be proceeding well.

Stephen Jay, M.D., was appointed national chairman of the Accreditation Council for Continuing Medical Education.

I would like to acknowledge the members of the Commission on Medical Education and the Subcommission on Accreditation for the time and study they contribute by attending meetings and making site surveys of accreditation. I would also like to acknowledge the fine support and help from Dorothy Martens, ISMA CME coordinator. Her help throughout the year has been invaluable.

COMMISSION ON PHYSICIAN ASSISTANCE

Robert Nelson, M.D., chairman

1992 has been a busy and productive year for the Commission on Physician Assistance (COPA). A key focus of the commission's work has been to expand and develop our program in an effort to generate revenue. As a result, we have officially established a contractual agreement to act as

the Physician Assistance Program for the Indiana University Medical Center staff. Training is currently underway with the IU physicians who will comprise the in-house committee along with Kete Cockrell, M.D., COPA medical consultant, and Candace Backer, COPA program coordinator.

The commission also has worked on developing a fee-for-service contract to offer to hospitals statewide. Under this plan, COPA would act as the Physician Assistance Program for a participating hospital, which would pay a pre-determined fee for our services. This contract would be negotiated annually. As part of this service, a fee would be established for all participating physicians and would be prorated based on membership status in the ISMA and their primary hospital. In developing this service, discussions have been held with representatives of the Indiana Hospital Association, who have received the program favorably.

In addition to developing and marketing fundraising ideas, COPA has continued to investigate new cases and monitor existing program participants. We are monitoring more than 50 cases, with approximately 80% being ISMA members. To date, four physicians have relapsed, three of whom were reported to the Medical Licensing Board due to their refusal to enter treatment for the relapse. Each physician lost his license but has since entered treatment.

Our program statistics continue to indicate family practitioners as the number one specialty we see, followed by emergency room physicians and anesthesiologists. Problems with alcohol/drugs comprise more than 80% of our cases, with psychiatric and

other problems constituting the remainder.

COMMISSION ON SPORTS MEDICINE

Ronald Blankenbaker, M.D., chairman

The Commission on Sports Medicine is primarily concerned about the health and safety of amateur and recreational athletes. We encourage physical fitness and good health habits through safe, effective sports activities that rely on modern sports medicine principles and ethical conditioning.

The commission has spent a great deal of time working with a local expert in nutrition, the Governor's Council on Physical Fitness and Sports Medicine and the Indiana State Department of Health to create educational materials that will encourage the wise use of dietary elements. Most importantly, these brochures (soon to be published) will assist physicians, athletic trainers, coaches, teachers and parents in their efforts to discourage the ingestion of improper foods and harmful supplements. There are many myths and misconceptions that are driven by inappropriate motivation that need to be overcome. In addition to the educational materials, we have presented exhibits and speeches to appropriate audiences.

The commission has researched the use of protective helmets for various sports and will soon be disseminating guidelines for the fitting and removal of helmets. Additionally, a position paper on "Concussion in Sports" is being developed.

During the past year, the commission has addressed other sports medicine related issues,

such as: efforts to improve the availability of certified athletic trainers in school athletics; legal protection for physicians who volunteer their services; youth fitness; the referee override rule for football injuries; when to disqualify an athlete from participation due to illness; locker room physicals; breakaway bases and protective face guards for baseball; sensible exercise shoes; and abuse of anabolic steroids.

The members of the commission and its Professional and Technical Advisory Subcommittee are eager to deal with sports medicine issues and concerns of the ISMA membership. We will give you our best effort to seek an expedient resolution to any problem you bring to our attention.

GRIEVANCE COMMITTEE **Richard Schnute, M.D., chairman**

The Grievance Committee, including Max Hoffman, M.D., John Pless, M.D., Anthony Pizzo, M.D., and Freeman Martin, M.D., investigated multiple complaints during the 1991-92 period and worked diligently to fairly resolve these issues.

Complaints included differences of opinion concerning diagnosis and treatment, fees and charges and accusations of im-

proper deportment. Most misunderstandings resulted from inadequate communication or explanations. The committee strongly urges better communication among physicians and patients.

As chairman, I thank the committee members for their participation in resolving these problems.

INDIANA MEDICINE **George T. Lukemeyer, M.D.,** **editorial board chairman**

INDIANA MEDICINE entered a new era in January 1992 as it changed the focus of its contents and the number of issues published annually. The changes were made in response to a readership survey and the recommendations of an ISMA communications task force.

The contents of the magazine changed to emphasize socioeconomic, practice management, legal, ethical, financial and regulatory issues. At least one peer-reviewed scientific article is included in each issue.

The magazine also changed the frequency of publication from monthly to bimonthly, with issues published in January, March, May, July, September and November.

All scientific manuscripts are now reviewed by one or more

members of the editorial board to determine their acceptability for publication. A significant number of articles are also submitted to outside reviewers for their evaluation and recommendations. Members reviewed 26 scientific articles from Aug. 1, 1991, to July 31, 1992.

Editorial board members met at the ISMA headquarters May 27, 1992, to consider topics for editorials and feature articles in future issues of INDIANA MEDICINE.

I would like to thank the following editorial board members for their assistance in reviewing manuscripts: James R. Buechler, M.D., Terre Haute; Thomas J. Conway, M.D., Terre Haute; James W. Edmondson, M.D., Indianapolis; Robert L. Forste, M.D., Columbus; George C. Manning, M.D., Fort Wayne; I.E. Michael, M.D., Indianapolis; Bruce F. Waller, M.D., Indianapolis; and Robert C. Ziss, M.D., Evansville. In addition, I appreciate the participation of the medical students who have served on the board, Paul Forman, Franklin Roesner and Ruchir Sehra.

I want to especially recognize Dr. Michael, whose term on the board ended Dec. 31, 1991. We thank him for his many years of service on the board. □

■ resolutions

Status of 1991 resolutions

RESOLUTION 91-1

Insurance Premium Increases

Introduced by:

Lake County Medical Society

Referred to:

ISMA Subcommittee on Insurance

Status:

While members of the Subcommittee on Insurance appreciate the intent of this resolution, meaningful recommendations for fee changes cannot be presented to the board several months in advance because they would be based on information that would be outdated by the time the board makes a decision. Because March 1 is the bill date for the period starting April 1, the board must decide on fee changes at its mid-January meeting. The subcommittee meets in the first or second week of January and makes recommendations based on claims experience through Dec. 31 of the preceding year. By following this procedure, fees are based more on actual experience and less on trend factors than would be possible if recommendations were made several months in advance and, therefore, are accurate and meaningful.

RESOLUTION 91-3

Health Insurance Experience

Introduced by:

Lake County Medical Society

Referred to:

Board of Trustees

Status:

Testimony at the reference committee supported leaving the distribution of premium increases to the discretion of the Subcommittee on Insurance and the Board of Trustees rather than assuming one standard approach (i.e., commensu-

rate with each plan's experience). Because the ISMA will renew with Lincoln National for only three months and then change to another insurer July 1, the subcommittee agreed that the best approach for April 1 was to apply the necessary increase across the board rather than by each plan's experience. Members of the subcommittee question the wisdom of locking in on either approach.

RESOLUTION 91-4

Addition to Cigarette-Package Warning

Introduced by:

Third District Medical Society

Referred to:

Indiana delegation to the American Medical Association

Status:

Resolution was introduced at the December 1991 AMA interim meeting. Substitute Resolution 221 was adopted as follows: "Resolved, that the American Medical Association continue its efforts to establish the United States as a smoke-free society by the year 2000 and that the association undertake the following specific actions:
1. Reaffirm existing Policy 101.025 in support of the elimination of federal price supports for farmers growing tobacco;
2. Modify existing Policy 101.017 calling for tobacco product warning labels to be printed in a clear and conspicuous manner by calling for all warning labels to be enlarged to cover at least 25% of the package front, print advertisement or billboard and to be set in a black and white block;
3. Expand on existing

Policy 109.060 calling for the addition of certain warning labels to include a label stating 'infants and children living with smokers have an increased risk of respiratory infections and cancer;' and 4. Comply with existing Policy 101.031 calling for a tobacco-free society progress report at every interim meeting until the year 2000."

RESOLUTION 91-5

Commission on Medical Economics

Introduced by:

Fifth District Medical Society

Referred to:

Board of Trustees

Status:

Ad Hoc Committee to Review Resolutions 91-5 and 91-11 was formed with reports due back to the board at the May and August meetings. Meetings of the committee were held April 29 and July 15. Discussion included review of the State Health Policy Commission report. Recommendations to be discussed at the Aug. 2 board meeting.

RESOLUTION 91-6

Educating Physicians in Pertinent Legal Matters

Introduced by:

Lawrence County Medical Society

Referred to:

ISMA Legal Counsel and Communications Department

Status:

Articles and information are being published in *ISMA Reports* and *Indiana Medicine*. *ISMA Reports* includes the monthly PICI risk management question-and-answer column. Since October 1991, *ISMA Reports* has carried articles on the federal government safe harbor regulations, workers compensation, HCFA final rules

on the Medicare fee schedule, OSHA's final regulations on bloodborne pathogens, the child abuse release statute and the EPA ban on Sporicidin. *Indiana Medicine* included articles on the Lawrance case, the Indiana Compensation Act for Patients and the Indiana Health Policy Commission. Also the communications department printed and distributed the "Your Right to Decide" brochure on advance directives. *ISMA Reports* published information on Medicare, OSHA audits and CLIA regulations. Publications continue to reflect changes and impact of changes in the practice of medicine.

RESOLUTION 91-7A

Introduced by:

Referred to:

Status:

Prohibit Corporal Punishment in Indiana Schools

John W. Luce, M.D.

ISMA Commission on Legislation and Legislative Department

Executive director met with Indiana State Teachers Association (ISTA) president and executive director expressing ISMA's position on corporal punishment. ISTA is on record with the National Education Association (NEA) in support of corporal punishment. Small rural school corporations tend to support corporal punishment whereas most metropolitan areas have policies in place that prohibit corporal punishment. ISTA will work with the ISMA on a local level with individual school corporations to educate and inform those areas of the child abuse statutes. No legislation was intro-

■ resolutions

duced in the 1992 General Assembly.

RESOLUTION 91-8 **Timely Distribution of ISMA Resolutions to County Medical Societies**
Fifth District Medical Society
Introduced by: ISMA Commission on Constitution and Bylaws
Referred to: Referred to the Commission on Constitution and Bylaws for implementation. Added to the *Constitution and Bylaws* and *Administrative Policy Manual*.
Status:

RESOLUTION 91-9 **Triplicate Prescription**
Fountain-Warren Medical Society
Introduced by: ISMA Legislative Department
Referred to: Letter sent Feb. 17 to the Health Professions Bureau requesting an audit. Response to ISMA letter circulated at March board meeting.
Status:

RESOLUTION 91-10A **PRO Committee**
Lake County Medical Society
Introduced by: ISMA PRO Liaison Committee
Referred to: Committee is attempting to secure volunteers to give second opinions on PRO quality decisions.
Status:

RESOLUTION 91-11 **ISMA Commission on Medical Services**
ISMA Executive Committee
Introduced by: Board of Trustees
Referred to: Ad Hoc Committee formed to review Resolutions 91-5 and 91-11 with report back to the board at the May meeting. Board approved recommendation by Ad Hoc Committee for termination of the Commission on Medical Services at its May 17

meeting. Commission on Constitution and Bylaws will make the appropriate changes in the bylaws.

RESOLUTION 91-13A **Utilization Review/Managed Care**
John Yarling, M.D.
Introduced by: ISMA Commission on Legislation and Legislative Department
Referred to: House Bill 1182 passed the 1992 General Assembly.
Status:

RESOLUTION 91-14 **The AMA "Principles of Medical Ethics"**
Wayne-Union County Medical Society
Introduced by: Indiana delegation to the American Medical Association
Referred to: Resolution was introduced at the December 1991 AMA interim meeting. The resolution was not adopted.
Status:

RESOLUTION 91-16 **Safety of Young Children**
Betty J. Campbell, M.D.
Introduced by: Board of Trustees
Referred to: Feasibility study and analysis of legislation for 1993 by ISMA Legislative Department with report at the May board meeting. Staff provided a priority list of legislative issues for the 1993 session including INCAP, Medicaid, HIV issues and allied health practitioner issues. Passage of a law prohibiting children under six to be allowed in the open beds of trucks and to expand the current passenger safety restraint laws would require considerable time, effort and political bargaining. In light of the full legislative agenda for 1993, introduction of this bill was deemed feasible but, at this time, inadvis-

able.

RESOLUTION 91-17A

Introduced by:

Referred to:

Status:

HBV/HIV Testing

Stephen D. Tharp, M.D.

ISMA Policy Manual for inclusion

Implemented by adding to policy manual.

RESOLUTION 91-19A

Introduced by:

Referred to:

Status:

HIV Testing

Delaware/Blackford County Medical Society

ISMA Commission on Legislation

House Bill 1399 did not pass the 1992 General Assembly. Staff met with Rep. Charlie Brown following the primary election. Staff's impression is that a great deal more ISMA grassroots support for this issue will need to be generated before Rep. Brown can be persuaded to hear the bill.

RESOLUTION 91-20

Introduced by:

Referred to:

Status:

Federal Legislative Issues/ Alerts

Vanderburgh County Medical Society

Board of Trustees

Ad Hoc Committee formed to review resolution 91-20 with report back at the May board meeting. The committee recommended the following action items:

1. Staff should work to ensure that the ISMA membership database contains accurate home addresses so important legislative information can be sent to physicians' home addresses.
2. The ISMA Legislative Hotline should be publicized through *ISMA Reports*, *Indiana Medicine* and other vehicles so members will use this resource more.
3. ISMA should disseminate information on how

individual physicians may subscribe to AMA's Fednet, how much it costs to subscribe and what type of computer equipment is necessary before a physician may subscribe to Fednet.

4. ISMA leadership should be encouraged to informally poll physicians to gauge the level of satisfaction with current communication mechanisms. Those who indicate dissatisfaction should be asked if they were aware of the ISMA Legislative Hotline.

RESOLUTION 91-21

Introduced by:

Referred to:

Status:

Non-Member Utilization of COPA

Vanderburgh County Medical Society

ISMA Commission on Physician Assistance

The plan that has been developed for consideration by the Indiana Hospital Association sets up a fee schedule for non-members, as well as a hardship category for physicians who cannot pay.

RESOLUTION 91-22A

Introduced by:

Referred to:

Status:

Laser Surgery - Medical Degree/License

Fort Wayne Medical Society and 12th District

ISMA Commission on Legislation

Indiana Academy of Ophthalmology (IAO) asked us not to introduce this legislation this year. The Commission on Legislation received the letter and voted to observe IAO's wishes. Staff met with IAO representatives and discussed strategies for 1993 introduction.

■ resolutions

RESOLUTION 91-23

Expansion of Senate Enrolled Act 30 to Include Medicaid Eligibility for Significantly Premature Infants

Introduced by: Fort Wayne Medical Society and 12th District
 Referred to: Board of Trustees
 Status: Feasibility study of legislation for 1993. Report back at the May meeting for review and action. Staff spoke with Sen. Gery who indicated interest in re-introducing in 1993.

RESOLUTION 91-25

Tobacco Products - Increased Taxation

Introduced by: Fort Wayne Medical Society and 12th District
 Referred to: ISMA Commission on Legislation and Legislative Department
 Status: Two bills were introduced - one in the House (HB 1366) and one in the Senate (SB 425). Neither passed.

RESOLUTION 91-28

Support to Continue and Enhance the IU Medical School Regional Centers

Introduced by: C. Dyke Egnatz, M.D.
 Referred to: ISMA Legislative and Communications Departments
 Status: No funding cutbacks.

RESOLUTION 91-29

Physician Responsibility to ISMA/AMA

Introduced by: C. Dyke Egnatz, M.D.
 Referred to: Board of Trustees
 Status: Implemented by the board through communication with physicians in their districts.

RESOLUTION 91-30

Medical Disciplinary Process

Introduced by: Stephen Tharp, M.D.
 Referred to: Board of Trustees, ISMA Legal Counsel and Legislative Department
 Status: a) No legislation introduced during 1992 session; legislation will be sought in 1993.
 b) Occurring on an ongoing basis.
 c) Occurring on an ongoing basis.
 d) Was not adopted in 1992 legislature. □

NO DICE.



For some malpractice carriers, easy come meant easy go. But not The Medical Protective Company. Our financial stability is a legend in our industry. And has been since we invented professional liability coverage at the

turn of the century. Ninety years in business and a continual A+ (Superior) rating from A.M. Best prove it. Don't gamble your premium dollars. Put your money on a sure thing and call our general agent today.

THE
MEDICAL PROTECTIVE COMPANY

Vernon E. Hoover, H. Jere Frey, Michael W. Kinzer
6100 North Keystone Avenue, Suite 237, P.O. Box 20576, Indianapolis, IN 46220 • (317) 255-6525

Robert B. Newell, J. Barton Lyon
Suite 240, 2260 Lake Avenue, P.O. Box 5174, Fort Wayne, IN 46895 • (219) 422-4783

Cardiac transplantation at IU Medical Center

L. Brick Rigden, M.D.
Sue Faust, R.N.
John Brown, M.D.
Yousuf Mahomed, M.D.
Kenneth A. Kesler, M.D.
Mark W. Turrentine, M.D.
Jacqueline O'Donnell, M.D.
Indianapolis

The first successful orthotopic cardiac transplantation was performed in 1967 in South Africa by Christian Barnard. However, due to poor clinical results, it remained an experimental procedure restricted to a few patients with severe cardiac disease and dismal life expectancies. The discovery of cyclosporine A and its first clinical use in 1981 helped improve actuarial survival dramatically, and the number of transplants performed has increased exponentially.

The indications and contraindications of cardiac transplantation have undergone closer scrutiny and revision as morbidity and mortality rates improved. Cardiac transplantation is no longer considered experimental, and most insurance companies and government agencies reimburse for this procedure.

Seventy-four patients have undergone transplantation at the Indiana University Medical Center since its cardiac transplantation program began in 1986. The current patient selection criteria and transplant contraindications of our program are reviewed in this ar-

ticle, and the five-year survival analysis is presented.

Selection criteria

Patients considered for cardiac transplantation must have end-stage heart disease. They frequently require recurrent hospitalizations for congestive heart failure, episodes of sudden death, persistent hypotension and marked disability. Many also have renal insufficiency or hepatic dysfunction as a result of poor cardiac function. These patients have failed optimal medical therapy, and no other surgical intervention, such as coronary bypass surgery or valve replacement, is deemed possible or beneficial.

The morbidity and mortality of their inherent disease are greater than that of cardiac transplantation. Specific pathologic states for which cardiac transplantation is considered include ischemic cardiomyopathy, idiopathic cardiomyopathy, congenital heart disease, postviral and postpartum cardiomyopathy and valvular heart disease.

Contraindications

The contraindications to cardiac transplantation (Table 1) involve the patient's ability to: 1) survive the perioperative period; 2) have minimal postoperative complications, both short-term and long-term; and 3) in view of the limited donor pool, have a good prognosis for survival from other medical

problems. Because of improved survival of cardiac transplant patients, once absolute contraindications now are often relative contraindications.

Pulmonary hypertension (pulmonary vascular resistance greater than 4-5 Wood units) is an absolute contraindication due to a high incidence of fatal right heart failure immediately after the transplant. A systemic infection, active

Table 1

Contraindications to cardiac transplantation at Indiana University Medical Center

- Severe pulmonary hypertension
- Recent pulmonary embolus or infarction
- Active infection
- Active peptic ulcer disease
- Diabetes mellitus
- Primary renal or hepatic disease
- Active malignancy
- AIDS
- Systemic disease likely to limit survival
- Alcohol or drug addiction
- Psychiatric or cognitive impairment likely to jeopardize compliance

peptic ulcer disease and recent pulmonary embolus or infarction are absolute contraindications while ongoing; however, after appropriate treatment and resolution, patients again can be considered for a transplant. Diabetes mellitus, due to a high incidence of glucose intolerance with corticosteroid immunosuppression and the frequent presence of end-organ and peripheral vascular disease, remains an absolute contraindication.

Primary renal or hepatic disease is a contraindication to cardiac transplantation as cyclosporine is hepatically metabolized and nephrotoxic. There is a high incidence of acute renal failure and chronic renal insufficiency postoperatively, even in patients with normal preoperative renal function.

Systemic diseases that are life-limiting, most often malignancies, also are absolute contraindications. Multiple medical problems, depending on their nature, also make patient eligibility less likely. AIDS, active hepatitis or tuberculosis are contraindications due to the inability to control these diseases after the initiation of immunosuppression.

Patient age is evaluated on a chronologic and physiologic basis. There is no age cutoff; patients are scrutinized with respect to viability, goals and motivation. With older patients, contraindications are reviewed more carefully, and relative contraindications are greater concerns. Additional screening tests often are required to exclude occult and serious disease.

An in-depth psychiatric history also is obtained. Alcohol and drug addiction are absolute contraindications. After the transplant, patients must assume re-

Table 2

**Recipients awaiting cardiac transplantation:
Diagnosis and age**

<u>Etiology</u>	<u>Number of patients (%)</u>	<u>Age distribution in years (mean age)</u>
Ischemic	26 (35%)	42-67 (54.0)
Idiopathic	24 (33%)	0-61 (37.0)
Congenital	19 (26%)	0-30 (3.5)
Valvular	4 (5%)	32-51 (42.0)
Postpartum	1 (1%)	24
Total	74	0-67

Table 3

**Patient status at time of transplantation:
Outpatient, requiring continuous intravenous inotropes,
or support with an intra-aortic balloon pump (IABP)**

	<u>Number of Patients</u>		
	<u>Males</u>	<u>Females</u>	<u>Total</u>
Outpatient	13	8	21
Inotropes	26	8	34
IABP*	17	2	19
Total	56	18	74

* All patients on an IABP also required continuous intravenous inotropic support.

sponsibility for their health care; they take multiple medications at specific times throughout the day. They are taught to recognize the early signs of post-transplant complications and must undergo frequent surveillance endomyocardial biopsies and follow-up clinic appointments. A history of behavioral or psychiatric illness that would jeopardize such compliance requires close scrutiny. A strong family support system also is sought.

Statistical methods

The Kaplan-Meier variable-interval method was used to perform the statistical analysis on the survival data. This method allows patients transplanted any time during the five-year period to be included in the statistical analysis. A survival curve is generated with each interval defined by a patient death.

The survival rate does not change in between deaths. This results in a "stair-step" survival

curve, with each vertical step representing a patient death. In our series, the death most remote from the date of surgery occurred at 36 months after the transplant. Using this method, the 36-month survival rate does not change to 60 months, the longest patient follow-up in our series. Limitations of this statistical method are caused by the relatively recent initiation of our transplant program and the limited number of patients who underwent transplantation more than 36 months ago.

Survival analysis results

Patient population – Seventy-four patients underwent cardiac transplantation at Indiana University Hospital or Riley Hospital for Children from June 1, 1986, through May 31, 1991, (56 males, 18 females). The indication for transplantation and the age distribution are presented in Table 2. Seventy percent of our transplants were for ischemic or idiopathic cardiomyopathy (90% of the adult population). The ischemic group has a narrower age distribution and an older mean age than the other four groups. Patients with idiopathic cardiomyopathy ranged in age from a few months to 61 years. All of the patients had NYHA Class III or IV heart failure. Many required prolonged hospitalization leading up to transplantation, frequently on continuous inotropic support or mechanical support with an intra-aortic balloon pump (Table 3). Hospitalization before transplantation ranged from zero to 164 days.

Patient deaths – Of the 74 patients transplanted, 12 died. Causes of death include respira-

Table 4

Cumulative survival rates for all patients undergoing cardiac transplantation at Indiana University Medical Center

<u>Months</u>	<u>Cumulative survival</u>
6	0.89 ± 0.04
12	0.86 ± 0.04
24	0.84 ± 0.05
36*	0.81 ± 0.05

* No deaths have occurred after 36 months, and 18 patients have follow-up greater than 36 months.

Table 5

Cumulative survival rates for adult patients undergoing cardiac transplantation at Indiana University Medical Center

<u>Months</u>	<u>Cumulative survival</u>
6	0.93 ± 0.04
12	0.91 ± 0.04
24	0.88 ± 0.05
36*	0.85 ± 0.05

* Maximum follow-up is 60 months for 17 patients. Five-year survival is 85%.

Table 6

Cumulative survival rates for pediatric patients undergoing cardiac transplantation at Indiana University Medical Center

<u>Months</u>	<u>Cumulative survival</u>
6	0.79 ± 0.10
12*	0.71 ± 0.11

* No deaths have occurred after 12 months; however, only two patients have survived more than 24 months with a maximum follow-up of 40 months.

tory failure and/or pulmonary hypertension (4), acute rejection (3), opportunistic infections (2), hepatitis (1), graft failure (1) and lymphoma (1). *Table 4* presents the cumulative survival rate at six, 12, 24 and 36 months. Our three-year survival is 81%, with a maximum follow-up of 60 months. No deaths have occurred after 36 months follow-up, and thus, the survival rate is unchanged to 60 months. There are 18 patients with follow-up greater than 36 months.

Five of the 12 deaths occurred among the 19 pediatric patients, and seven deaths occurred in the adult population of 55 patients. *Table 5* and *Table 6* separate the cumulative survival data into pediatric and adult populations. A greater one-year survival rate is found in adult patients when compared to children, 91% versus 71%. In the adult population, the 36-month survival rate is 85%. The maximum follow-up is again 60 months. The pediatric program was established more recently, and only two patients have follow-up greater than two years, resulting in the limited data available for that group.

Most deaths occurred within the first three months of surgery (8 of 12 deaths), reflecting acute perioperative complications in patients who were premorbid before transplantation. It is well-established that several parameters, if present before the transplant, are associated with decreased survival: 1) need for intravenous inotropic support; 2) mechanical support with the intra-aortic balloon pump; and 3) evidence of poor perfusion with end-organ dysfunction.

A conditional survival analy-

sis was performed on the patients who survived more than three months after the transplant. Sixty-six patients – 51 adults and 15 children – survived more than three months. Of these patients, one child and three adults died. After excluding the patients who died within the first three months of surgery, the 36-month cumulative survival improved from 81% to 91%. In addition, the one-year survival rate within the pediatric group becomes more comparable to the adult group (91% and 98%, respectively). Again, these early deaths occurred in patients who were the most critically ill and

thus at greatest risk.

Table 7 compares the cumulative survival data to several large cardiac transplant programs in this country. These programs have larger patient populations with longer longitudinal follow-up. Our five-year data compare favorably to these centers.

Discussion

The five-year experience in cardiac transplantation at the IU Medical Center is very promising. Previous studies have documented a one-year mortality of Class III to IV congestive heart failure of 35% to 50%.¹ Others

Table 7
Survival rates for adult cardiac transplant patients at several cardiac transplant centers³

Center	Actuarial survival (%)		
	Years after transplant 1	3	5
Stanford University (N = 355)	82	67	60
Texas Heart Institute (N = 204)	87	69	
Utah Cardiac Transplant Program (N = 254)	89	80	
Loyola University (N = 137)	83	74 (@ 4 yrs)	
St. Louis University (N = 85)	83	81	
Indiana University (N = 55)	91	85	85

Used with the permission of Sandoz Pharmaceuticals Corp.

have disclosed a negligible two-year survival in patients with idiopathic cardiomyopathy and an ejection fraction of less than 20%.² Most of our patients had this degree of cardiac dysfunction and symptomatology before transplantation; many required continuous intravenous inotropic support or mechanical support with an intra-aortic balloon pump as a bridge to transplantation. Their prognosis, dismal without transplantation, improved to greater than 80% five-year survival after successful cardiac transplantation.

The discrepancy between survival in children and adults reflects the high perioperative mortality of neonates with severe congenital defects. This discrepancy is narrowed in the conditional analysis comparing patients who survived at least three months. The conditional analysis confirms that the highest mortality is in the early post-transplant period and that those patients who weather the initial difficulties have an excellent five-year survival.

These encouraging results reflect advances in immunosuppressive therapy and infection control, as well as strict patient selection criteria and the exhaustive pre-transplant evaluation. In addition, patients are closely fol-

lowed after the transplant with frequent surveillance endomyocardial biopsies and adjustments of their immunosuppressive therapy by a dedicated cardiac transplant team.

We are pleased with the five-year results of our cardiac transplant program. In addition to an overall 81% five-year survival, our patients have a marked improvement in their quality of life, and their congestive symptoms are resolved. Most can participate in hobbies and sports, and some return to work.

However, the growth of cardiac transplantation is limited by the finite number of donor organs, and as a result, at least 20% to 25% of candidates die while waiting for a transplant. Greater awareness of organ donation and continued improvement in immunosuppression and patient management should contribute to continued successes in cardiac transplantation. With such excellent survival statistics, cardiac transplantation is a viable therapeutic option in patients with end-stage heart disease. □

Dr. Rigden is a cardiology fellow at the Krannert Institute of Cardiology in Indianapolis.

Ms. Faust is senior cardiac

transplant coordinator at the Indiana University Medical Center in Indianapolis.

Dr. Brown is a professor of surgery and a cardiothoracic surgeon at the Indiana University Medical Center.

Dr. Mahomed is an associate professor of surgery at the Indiana University Medical Center.

Dr. Kesler and Dr. Turrentine are assistant professors of surgery at the Indiana University Medical Center.

Dr. O'Donnell is professor of medicine and medical director of cardiac transplantation at the Indiana University Medical Center and a research associate at the Krannert Institute.

Correspondence and reprints: Jacqueline O'Donnell, M.D., Krannert Institute of Cardiology, 1111 W. 10th St., Indianapolis, IN 46202-4800.

References

1. Cohn JN, Rector TS: Prognosis of congestive heart failure and predictors of mortality. *Am J Cardiol*, 62:25A-30A, 1988.
2. O'Connell JB, Gunor RM: Dilated congestive cardiomyopathy: Prognostic features and therapy. *Heart Transplant*, 2(1):7, 1982.
3. Strategies for long-term patient management in heart transplantation: A slide/lecture program. Sandoz Pharmaceuticals Corp., East Hanover, NJ; March 1990.



ARNETT CLINIC

Lafayette, Indiana

About the Multispecialty Medical Group

Arnett Clinic has served Tippecanoe County and surrounding counties in Mid-North Central Indiana since 1922. Arnett physicians introduced the area's first dialysis service, performed the area's first open heart surgery, and developed the community's first heart catheterization laboratory. In four outpatient facilities, over 85 specialists and subspecialists provide medical and surgical services in virtually every specialty field. The bulk of Arnett's referral patients reside within a fourteen-county area surrounding Lafayette, Indiana, with a drawing area of over 300,000 people.

Ambulatory walk-in clinics in Lafayette and West Lafayette supplement primary clinic services. Arnett Urgent Care Centers are open from 8 a.m. until 8 p.m. every day, and staff members provide diagnosis and treatment for any medical problem which does not require ambulance transport.

Arnett physicians provide hospital support services at two nearby community hospitals, Home Hospital with 365 beds, and St. Elizabeth Hospital with 375 beds. Arnett has diversified into other healthcare fields, including Arnett Health Systems (an HMO) and the corporate affiliates of Arnett Medical Supply and Arnett Pharmacy.

Opportunities

The Arnett Clinic is currently seeking BE/BC candidates: Non-invasive Cardiology, Dermatology, General Internal Medicine, OB/GYN, Orthopaedics, Pediatrics, Urology.

Practice Setting

At this time, over 85 physicians work for Arnett Clinic. One of the most practical reasons for affiliation with Arnett is the availability of ancillary staff to support clinic operations. Administrative, Laboratory, and Radiology services are available on-site, making our practice environment an integrated, comprehensive, and convenient healthcare resource center. The patient base in Lafayette stems from a balanced mix of industrial and university communities. We are an equal opportunity employer.

Benefits

Our Medical Staff members enjoy competitive salaries and a generous benefit package. During the first two years of employment, Arnett offers a guaranteed minimum salary with a production bonus. After two years of successful practice experience, shareholder status with a productivity incentive formula is available. An excellent profit-sharing and investment plan is also available.

Other benefits include health coverage via Arnett HMO or other group insurance, disability, and life insurance plans. A generous fund for continuing education is available to clinic physicians.

Community

Lafayette, Indiana is a thriving, low-crime community located in a county of approximately 132,000 people. Purdue University, known for academic leadership in the areas of engineering, agriculture, humanities, and sciences, and for Big Ten Sports, is nearby. *Money Magazine* recently identified Lafayette as one of the top 14 cities in which to live in the U.S.A.

For more information, please contact:

John C. Horner
Director of Physician Recruitment
Arnett Clinic
2600 Greenbush Street
Lafayette, IN 47904
(317) 448-8000
Toll Free Nationwide, 1-800-899-8448

Maternal mortality in Indiana: A report of maternal deaths in 1990

William D. Ragan, M.D.
Indianapolis

This is the annual report of the Indiana Maternal Mortality Study Committee. In 1990, Indiana reported eight maternal deaths and 85,986 live births. This gives the state a maternal mortality ratio of 9.3 per 100,000 births for 1990.

The committee met at 11:30 a.m. June 12, 1991, at the Indiana University Medical Center Student Union Building for a closed discussion of the eight 1990 deaths. Each case was presented for discussion, establishment of diagnosis and assignment regarding preventability and responsibility.

The following eight deaths were discussed:

Case 797 – Jan. 4, 1990. A 23-year-old single white woman, G3, P3, two weeks post partum. Death was considered obstetric and indirect. Cause of death was medical complication and pregnancy. Cerebral vascular accident.

Case 798 – Jan. 23, 1990. A 30-year-old divorced white woman, G4, P3, 24 weeks' gestation. Death was considered non-obstetric. Cause of death was drug overdose.

Case 799 – June 6, 1990. A 37-year-old married white woman,

G3, P3, 24 weeks' twin gestation. Death was considered obstetric and direct. Cause of death was infection (*Clostridia perfringens*).

Case 800 – June 6, 1990. A 30-year-old married black woman, G9, 34 weeks' gestation. Death was considered obstetric and direct. Cause of death was hemorrhage. Rupture of the uterus.

Case 801 – Aug. 16, 1990. A 25-year-old married white woman, G1, P1, four weeks post partum. Death was considered non-obstetric. Cause of death was adenocarcinoma of the colon.

Case 802 – July 25, 1990. A 40-year-old married white woman, gravidity unknown, 2 1/2 weeks post partum. Death was considered obstetric and indirect. Cause of death was postcesarean section intestinal obstruction.

Case 803 – Sept. 12, 1990. A 33-year-old married black woman, G3, P2, AB1, six months post partum. Death was considered obstetric and indirect. Cause of death was medical complication and pregnancy. Acute myocardial infarction.

Case 804 – Dec. 20, 1990. A 30-year-old married black woman, G2, P1, 34 weeks' gestation. Death was considered obstetric and indirect. Cause of death was medical complication and pregnancy. Heart disease (Eisenmenger's complex).

Discussion

There appears to be a changing trend as to the cause of maternal mortality. The time-honored causes of hemorrhage, infection and toxemia have now been replaced in the United States by embolism, non-obstetric injuries, hypertensive disease of pregnancy, ectopic pregnancy and obstetric hemorrhage.¹⁻³ In Indiana, the leading causes of death are now medical complication and pregnancy, hemorrhage, embolism, infection, toxemia and anesthesia.^{4,5}

The leading cause of maternal death in the United States is pulmonary embolism. Thromboembolism remains an enigma, because early recognition and prevention can be difficult. There are 10 cases of air embolism in the Indiana statistics, which often are related to oral/genital activity. Education of antepartum patients would be helpful in these cases.⁶ Fortunately, amniotic fluid embolism is a rarity.

In Indiana, maternal death due to ruptured ectopic pregnancy has not occurred since 1984. Early diagnosis of this condition is now possible with sensitive pregnancy tests, ultrasound and laparoscopy.

Deaths due to toxemia often represent a lack of prenatal care, a situation that can be improved upon. Physician education, in-

creased availability of prenatal care and proper referral may help the pregnant patient with a medical complication. Because it is projected that AIDS will increase among women, more cases of pregnancy-associated deaths due to this cause will occur.⁷

There has been concern that the rising cesarean section rates in the United States might result in an increase in maternal mortality. At least one article, however, has shown that the risk of maternal death from cesarean section is low.⁸

There is a continuing effort on the part of the American College of Obstetricians and Gynecologists and the Centers for Disease Control (CDC) in Atlanta to collect data on maternal deaths by states and districts.¹ The CDC recently initiated a pregnancy mortality surveillance study.

The U.S. Department of Health and Human Services has set a goal of no more than 3.3 maternal deaths per 100,000 live births by the year 2000.⁹ In the United States in 1985, the maternal mortality ratio for all races was 7.8 per 100,000 live births. For white women, the ratio was 5.2; for all other races, it was 18.1. For black women, the ratio was 20.4 per 100,000 live births. The high maternal mortality rate for nonwhite

women is a problem that needs to be overcome.¹⁰ Combined efforts by these organizations should provide more meaningful statistics to curtail preventable maternal mortality in the United States.

Several recent articles have pointed out that maternal mortality is one of the great neglected problems of health care in developing countries. Rates are as much as 100 times higher than those seen in industrialized countries.^{11,12}

A year ago a "check box" asking if the deceased was pregnant was placed on the Indiana death certificate to help ensure that there are no missed cases. While the numbers are small, the Indiana State Maternal Mortality Study Committee believes that it is important to continue to investigate and report these deaths for statistical and educational purposes. According to our records, many of these deaths are preventable or have preventable factors. In addition there are many "near misses." We must remain vigilant. □

Correspondence: William D. Ragan, M.D., Wishard Memorial Hospital, Department OB GYN F-5, 1001 W. 10th St., Indianapolis, IN 46202.

References

1. Rochat RW, et al: Maternal mortality in the United States: Report from the Maternal Mortality Collaborative. *Obstet Gynecol*, 72:91-97, 1988.
2. Sachs BP, Brown D, Driscoll SG, et al: Maternal mortality in Massachusetts trend and prevention. *N Engl J Med*, 316:667-672, 1987.
3. Atrash HK, et al: Maternal mortality in the United States, 1979-1986. *Obstet Gynecol*, 76(6):1055-1060, 1990.
4. Ragan WD: Maternal mortality in Indiana: A report of maternal deaths in 1988. *Indiana Med*, 83:730-731, 1990.
5. Ragan WD: Maternal mortality in Indiana: A report of maternal deaths in 1989. *Indiana Med*, 84:704-705, 1991.
6. Ragan WD: Antepartum air embolism. *J Indiana State Med Assoc*, 74:30-32, 1981.
7. Koonin LM, Ellerbrock TV, et al: Pregnancy associated deaths due to AIDS in the United States. *JAMA*, 71:1306-1327, 1988.
8. Sachs BP, et al: Cesarean section-related maternal mortality in Massachusetts, 1954-1985. *Obstet Gynecol*, 71:385-388, 1988.
9. U.S. Department of Health and Human Services. Healthy People 2000: National Health Promotion and Disease Prevention Objectives, Conference Edition. Hyattsville, Md: Public Health Service, 1991.
10. Ellerbrock T, Atrash HK, Hogue C, et al: Pregnancy mortality surveillance: a new initiative. *Contemp Obstet Gynecol*, 31:23-24, 1988.
11. Rosenfield A: Maternal mortality in developing countries. *JAMA*, 262:376-379, 1989.
12. Languardía DD, et al: A 10-year review of maternal mortality in a municipal hospital in Rio de Janeiro: A cause for concern. *Obstet Gynecol*, 75:27-32, 1990.

YOCON[®]

YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

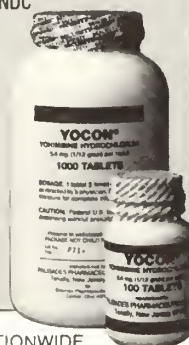
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

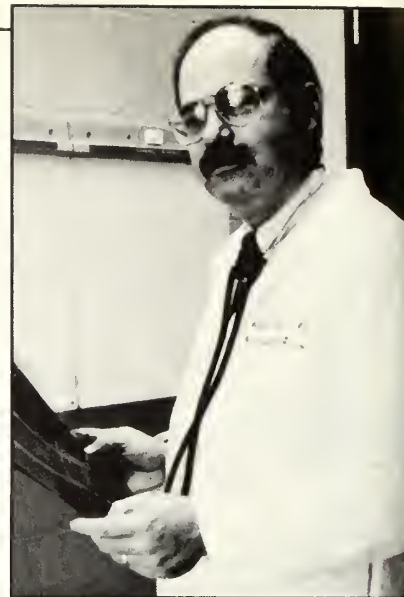
Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

**PALISADES
PHARMACEUTICALS, INC.**

219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083



Sure...

you're a good physician, but can you write?

Most physicians today need more than knowledge of medicine and good clinical ability to be successful. One of the tools you need is the ability to write well: to be able to put together a report of research that's worth publishing, to write a grant proposal that's fundable, to prepare a paper or exhibit for presentation that's well received.

We don't guarantee that you'll write a best seller or get a million-dollar grant, but we can guarantee that if you join us, you'll learn how to improve your writing, enhance the quality of your presentations, and keep up-to-date with developments in areas like desktop publishing.

We're an organization founded by physicians 50 years ago, and we're over 3000 strong. Among our members are people like you, for whom writing has become an increasingly important part of life. Find out more about us.

Send this coupon or call AMWA's national office at 301-493-0003.

Executive Director, AMWA
9650 Rockville Pike
Bethesda, MD 20814



Please send information about AMWA to:

Name _____

Address _____

Title (or specialty) _____

City _____ State _____ Zip _____



SNAKEROOT **E X T R A C T**

PUBLISHED BY THE
 INDIANA MEDICAL HISTORY MUSEUM
 IN ASSOCIATION WITH
 THE INDIANA HISTORICAL SOCIETY

NUMBER 25

FALL 1992

EXHIBIT TO FEATURE DENTAL ADVANCEMENTS

The Indiana Medical History Museum will open a new exhibit this October that will highlight the various contributions that America has made towards the advancement of professional dentistry.

The exhibit, scheduled to open Oct. 25, will examine the establishment of the first dental college, the discovery of anesthesia, the development of fluoridation and the other contributions Americans have made. The exhibit also will trace the ways these advancements changed the practice of dentistry.

Many concepts that established dentistry as an independent profession originated in France during the 1700s. Previously, most physicians provided dental care for their patients as part of their medical practices.

However, the French Revolution (1789-1799) temporarily suspended the advancement of the health sciences and prompted the emigration of many dental practitioners. Exposed to the new concepts, dentists in the United States established the educational institutions, national organizations and scientific literature necessary to

provide the foundation for professional dentistry.

Horace H. Hayden (1769-1844) and Chapin A. Harris (1806-1860) founded the world's first dental college in 1840, when they established the Baltimore College of Dental Surgery in Baltimore, Maryland. During the two-year program, students received instruction during four months of each year and acquired experience with practicing dentists during the remaining months.

In addition, Hayden and Harris formed the American Society of Dental Surgeons, the world's first national association of dentists. Although Hayden had conceived the idea as early as 1817, Hayden was unsuccessful in creating a national organization until he and Harris collaborated in 1840.

Besides the need for a national organization, Harris also understood the necessity for an authoritative dental periodical to distribute the latest information. Thus, in 1839, Harris had created the *American Journal of Dental Science*.

(See "Exhibit" on Page 2)

ANNUAL MEETING TO EXPLORE DENTISTRY

The Indiana Medical History Museum will examine the evolution of the dental profession in America when the museum conducts its annual meeting this October.

Peter H. Jacobsohn, D.D.S., vice-president, American Academy of the History of Dentistry, will speak about those individuals who most influenced the profession's advancement. Jacobsohn serves as chairman of the Department of Oral and Maxillofacial Surgery Services at the Marquette University School of Dentistry in Milwaukee, Wis.

The annual meeting, which is open to the public, will occur from 3 p.m. to 5 p.m., Sunday, Oct. 25, at the museum. The presentation, accompanied by slides, will proceed the opening of the museum's new exhibit on the history of dentistry.

During the lecture, Jacobsohn will explain the techniques and instruments that physicians and, eventually, dentists used to provide dental care. He also will explore the practice of dentistry during the Civil War.

During an informal reception afterwards, the audience may meet Dr. Jacobsohn and examine various dental instruments. In addition, people attending the annual meeting may tour the Indiana Medical History Museum.

[For more information, interested people should contact the Indiana Medical History Museum at (317) 635-7329.]



Horace H. Hayden (1769-1844) and Chapin A. Harris (1806-1860) founded the world's first dental college in 1840, when they established the Baltimore College of Dental Surgery in Baltimore, Maryland. The initial class contained five students.

EXHIBIT

(Continued from Page 1)

In addition to creating this professional foundation, dentists in America contributed to the discovery of anesthesia. However, an unresolved dispute exists about the origins of this medical discovery.

As early as 1831, people knew about the existence of nitrous oxide gas, ether and chloroform. Yet, medical applications of the pain-relieving properties of these anesthetic agents did not occur until the 1840s.

In 1845, the dentist Horace Wells (1815-1848) attempted to demonstrate the pain-relieving properties of nitrous oxide gas at the Massachusetts General Hospital in Boston. However, the demonstration did not succeed because Wells stopped administering the gas too soon and the patient cried out in apparent pain.

Although medical practitioners did not accept the discovery, Wells continued to use nitrous oxide gas during extractions. In addition, he discussed his results with other dentists, including William T. G. Morton (1819-1868).

At the suggestion of the chemist Charles Jackson (1805-1880), Morton began to explore the ability of ether to cause unconsciousness. In 1846, Morton successfully demonstrated the pain-relieving properties of ether at the Massachusetts General Hospital.

When the United States Congress offered an honorarium of \$10,000 to the discoverer of anesthesia, Wells, Morton and Jackson



"Ether Day" (1882) by Robert Hinckley illustrates the first successful demonstration of the pain-relieving properties of ether at Massachusetts General Hospital in 1846. The painting depicts the dentist William T. G. Morton (1819-1868), holding the glass inhaler he used to administer the anesthetic, as he observes a physician perform an operation to remove a tumor.

all applied. The physician Crawford W. Long (1815-1878) also desired the honorarium since he had performed three minor surgical procedures using ether in 1842.

Besides these contributions, dentists in America also introduced fluoridation as an effective method for the prevention of tooth decay.

In 1901, Frederick S. McKay, D.D.S. (1874-1959), noticed that many patients near Colorado Springs, Colorado, had unsightly dark stains on their otherwise healthy teeth. By the 1920s, McKay had asked the United States Public Health Service to help track the enamel disorder.

The subsequent investigations, headed by H. Trendley Dean, D.D.S. (1893-1962),

of the National Institute of Health, indicated that children who lived in areas where the water supply contained one part fluoride per million parts water had fewer cavities than their peers who lived in communities with fluoride-free water. As a result, the U. S. Public Health Service initiated a long-term study during the 1940s which successfully demonstrated the effectiveness of artificial fluoridation in preventing tooth decay.

[Sources: American Contributions to the New Age of Dental Research (1988) by the U.S. Department of Health and Human Services; Dentistry: A Historical Perspective (1988) by Dr. Milton B. Asbell; and Dentistry: An Illustrated History (1985) by Malvin E. Ring, D.D.S.]

I.U. SCHOOL OF DENTISTRY DEVELOPED FIRST TOOTHPASTE WITH STANNOUS FLUORIDE

A researcher at the Indiana University School of Dentistry developed the first toothpaste to contain stannous fluoride as an effective preventive of tooth decay.

Joseph C. Muhler, D.D.S., learned that stannous fluoride could prevent tooth decay during initial tests at Indiana University in 1945. That discovery led to large-scale clinical trials during the 1950s to prove the effectiveness of a new toothpaste that Procter and Gamble, Inc., of Cincinnati, Ohio, eventually produced as Crest.

"The toothpaste is no substitute for community water fluoridation," noted Dr. Muhler during an interview in 1956. "But many communities are taking painfully long to fluoridate their water, and forty per cent of the population doesn't drink 'city water'."

Thus, Dr. Muhler hoped the new toothpaste would benefit the large number of people who did not have access to fluori-

dated water or could not afford the expense of fluoride applications by dentists.

Stannous — or tin — fluoride resembles the sodium fluoride used by communities in their water supply. Both fluorides strengthen the surface enamel of teeth and increase the resistance of teeth to the microorganisms that cause decay.

The large-scale clinical trials required to prove the effectiveness of stannous fluoride began in 1952. They involved more than 16,000 adults and children in Bloomington, Indiana, and the surrounding communities.

After enrolling in the studies, participants received extensive dental examinations. After providing several tubes of toothpaste, the investigators instructed the participants to continue their normal brushing habits and to return every six months for additional examinations.

Snakeroot Extract derives its name from the white snakeroot plant, which significantly impacted medical history in Indiana. Many early Hoosiers experienced milk sickness, a mysterious disease the cause of which remained unknown until the 1920s. At that time, physicians traced the disease to the white snakeroot, or rather, to the consumption of milk from cows that had grazed on the plant. The white snakeroot contains the poison tremetol.

The Indiana Medical History Museum publishes **Snakeroot Extract** in association with the Indiana Historical Society. Thus, the members of the museum and the members of the Indiana Historical Society (who request this publication) receive this newsletter. Individuals should direct inquiries about membership in the Indiana Historical Society to: Indiana Historical Society, 315 West Ohio Street, Indianapolis, IN 46202-3299, (317) 232-1882.

Interested individuals should submit items for publication and direct any inquiries about museum membership to: Oren S. Cooley, Indiana Medical History Museum, 3000 West Washington Street, Indianapolis, IN 46222-4055, (317) 635-7329.

TUBERCULOSIS WIDESPREAD DURING PREVIOUS CENTURY

Tuberculosis remained prevalent during the 1800s because of inadequate diagnostic techniques, insufficient knowledge about the cause and transmission of the disease and a resigned acceptance that no effective method existed to prevent or cure the illness.

Before the 1800s, physicians did not correlate chest pains, fevers and other physical disorders as early symptoms of phthisis, the term then used to refer to tuberculosis. As a result, physicians often did not detect this contagious disease until the illness had progressed to its late stage.

In 1804, the French physician René Théophile Hyacinthe Laënnec (1781-1826) theorized that phthisis progresses through different stages, thereby displacing the belief that phthisis included six independent diseases. After inventing the stethoscope in 1816, Laënnec used mediate auscultation — the process of listening for sounds in the body by using an instrument — to correlate further the clinical and pathological symptoms of phthisis.

Since most physicians did not immediately accept these advancements, physicians continued to prescribe treatments that attempted to counteract the emaciation which occurs in the late stage of phthisis. Thus, physicians advocated diets rich in meat and dairy products and recommended strenuous exercise such as horseback riding and dancing.

During the middle 1800s, however, physicians began to stress the importance of fresh air, salubrious climate and sanitation in the treatment of tuberculosis, even though physicians disagreed about the



The emphasis on the therapeutic value of fresh air as a treatment for tuberculosis prompted the establishment of sanatoria in mountainous regions and along seashores during the middle 1800s. Patients, shown here at the Adirondack Cottage Sanatorium in Saranac Lake, New York, underwent strict regimens of quiet rest near open windows or on outdoor balconies throughout the various seasons.

cause of the disease. The advocacy of these treatments coincided with the growth of reform movements which attempted to combat the squalor and other problems that the Industrial Revolution had created.

The continued emphasis on the therapeutic value of fresh air prompted the establishment of sanatoria in mountainous regions, along seashores and in areas that possessed mild climates and sparse populations. By the 1880s, most patients that acquired fresh-air treatments at these sanatoria underwent strict regimens of quiet rest near open windows or on outdoor balconies throughout the various seasons.

Despite the advances in diagnostic equipment and the emphasis on fresh-air treatments, most people during the late 1800s accepted the existence of tuberculosis as a contagious disease for which no

effective cure existed. However, the discovery by the German physician Robert Koch (1843-1910) of the microorganism which causes tuberculosis eventually changed the resigned attitude with which most people regarded the illness.

Although Koch first identified the microorganism in 1882, the discovery did not impact the treatment and prevention of tuberculosis immediately. However, the discovery eventually prompted the creation of vaccines to immunize healthy people against infection and the development of antimicrobial drugs to effectively treat tuberculosis.

[Sources: Sickness and Health in America: Readings in the History of Medicine and Public Health (1985) by Judith Walzer Leavitt and Ronald L. Numbers; A History of the Therapy of Tuberculosis (1956) by Esmond R. Long, M.D.; The White Plague: Tuberculosis, Man and Society (1952) by René and Jean Dubos.]



The medical care offered at Sunnyside Sanatorium, which opened in 1917 near Oaklandon, Indiana, stressed not only the effectiveness of quiet rest in the treatment of tuberculosis but also the importance of community measures to prevent the spread of the disease. The discovery of the microorganism that causes tuberculosis eventually led to the development of vaccines and antimicrobial drugs to combat the disease and ultimately changed the public's resigned attitude that tuberculosis existed as an illness against which people could take few measures.

HYDROPATHY OFFERED PATIENTS "WATER-CURE" THERAPIES

Many people resorted to the "water-cure" therapies of hydropony during the early and middle 1800s to treat toothaches, fevers, hemorrhages, deafness and other afflictions.

Although hydropony existed during the 1700s, Vincent Priessnitz (1799-1851), a Silesian peasant, first proposed the "water-cure" system during the late 1820s after he used water treatments to cure his broken ribs. However, hydropony became popular in the United States because of the techniques developed by Dr. Joel Shew during the 1840s.

Shew proposed that water worked most effectively as a healing agent when administered gradually through the skin, a process he termed "transudation." Although a practitioner could use different applicators, a hydropony typically used sheets to administer the required treatments.

After dipping the cotton or linen sheet in cold water, the practitioner spread the wet sheet on several blankets, wound the sheet and then the blankets around the patient, secured the wrappings with large pins and, then, placed a feather mattress on top of the bundle. Depending on the seriousness of

the condition, the patient remained in this position from thirty minutes to several hours.

In addition to sheets, most hydropony also utilized a water girdle to apply treatments to a patient. Worn for varying periods of the day, the water girdle, which consisted of three yards of toweling, required that the patient soak the garment every three hours in cold water.

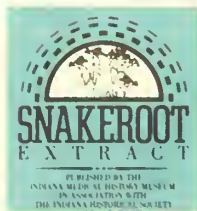
Besides applying wet sheets and recommending water girdles, the practitioners of hydropony often required a patient to undergo treatments in water baths. Of these vessels, the sitz bath enjoyed the most popularity.

The hydropony filled the sitz bath with enough water to cover the patient's abdomen, thereby allowing the person to remain partially dressed. After placing the patient's head, arms and legs at various angles, the hydropony required that the person remain in the sitz bath from twenty to thirty minutes.

[Sources: *The Midwest Pioneer: His Ills, Cures and Doctors* (1946) by Madge E. Pickard and R. Carhyle Buley; and *The Principles and Practice of Hydropony: A Guide to the Application of Water in Disease* (1898) by Simon Baruch, M.D.]



The practitioners of hydropony stressed that water worked most effectively as a healing agent when administered gradually through the skin. Although hydropony could use different applicators, the practitioners typically used sheets to administer the required treatments as this illustration from an 1898 textbook depicts.



Indiana Medical History Museum
3000 West Washington Street
Indianapolis, IN 46222-4055
(317) 635-7329



Butterworth
HEALTH SYSTEM

The Science of Healing...The Art of Caring

Exceptional professional and recreational choices are yours in West Michigan. Due to rapid growth, the Butterworth Health System offers attractive professional positions in its 530 bed tertiary care teaching hospital, 4 affiliate hospitals, and 7 Med+Centers. Positions are available in pediatrics, medicine/pediatrics, internal medicine, surgery, orthopedic surgery, otolaryngology, radiology, and OB/GYN. Opportunities include group practice, partnership, and solo or salaried urgent care and outpatient practices.

Choose Butterworth Hospital in Grand Rapids, which serves a population of 700,000, plus a 13 county referral area, or a small community or rural environment at one of the affiliate hospitals. Grand Rapids is West Michigan's cultural, educational, and economic center. With Lake Michigan only 30 miles away and numerous forests and parks nearby, there are ample opportunities for recreation and entertainment. Listed below are a few of the many opportunities available.

• **Family Practitioner/Outpatient Practice** BC/BE family practitioner full-time, 4 1/2 days, Monday through Friday. Established satellite outpatient practice, offering continuity of care, no call and regularly scheduled hours. OB, call, and hospital practice optional. Full benefit package, competitive salary with quarterly and year-end bonus. Opportunity to work additional hours in Med+Center, if desired.

• **Family Practitioner/Private Practice** Three well established and thriving group practices at Butterworth Hospital desire to expand by adding an additional BC/BE family practitioner. Join existing groups consisting of 2 - 5 physicians, OB optional. Desirable call schedules, competitive salaries and benefit packages.

• **Family Practitioner/Urgent Care Center** Join the growing field of ambulatory care, Med+Center BC/BE family practitioner needed to provide medical services to patients on a regularly scheduled basis. No call schedule, flexible hours, excellent compensation and benefits.

• **Family Practitioner/Primary Care Clinic** BC/BE family practitioner or internist needed for a large, primary care medical and dental clinic in Grand Rapids. The clinic is managed by Butterworth Ventures, the largest health care system in West Michigan and funded by private donations and a federal grant. Staffing includes 2 family practitioners, a pediatrician, nurse practitioner, medical director and support personnel. This is a salaried position with a competitive compensation and benefit package and 1 in 5 call schedule.

• **Internal Medicine/Faculty Position** Board certified general internist with teaching and clinical skills needed to join dynamic full-time academic faculty for internal medicine residency. Responsibilities include direct patient care in faculty practice, supervision and teaching of residents and students in both outpatient and inpatient settings. Competitive salary and benefits. Protected time is available for research and teaching.

• **Internal Medicine/Emergency Medicine** Immediate opening for a BC/BE internist with emergency medicine experience. Join a rapidly growing group of internists who cover the Emergency Room and in-house patients at United Memorial Hospital in Greenville, Michigan (1 hour from Lake Michigan and 35 miles from Butterworth Hospital). Flexible hours, no call, excellent reimbursement and benefit package.

• **Multi-Specialty Outpatient Group: Family Practitioner, Med/Peds, Internal Medicine, Pediatrician**

Dynamic 7 physician multi-specialty group providing outpatient care at United Memorial Hospital seeks additional physicians. Full-time position, 4 1/2 days Monday through Friday with additional hours available in the urgent care center or Emergency Room. Located in Greenville, Michigan (1 hour from Lake Michigan and 35 miles from Butterworth Hospital). Call and inpatient care is optional with opportunities available to do procedures in the hospital or office. Competitive salary and full benefit package including malpractice

**For information about the above positions, please call or write to
Nancy Martens, Manager Medical Staff Placement 1-800-788-8410.**

**Butterworth Health System, MC 73, Nancy Martens, 100 Michigan NE,
Grand Rapids, Michigan 49503**

■ auxiliary report

Trudy Urgena ISMA Auxiliary President

The Indiana State Medical Association Auxiliary is now a component organization of the newly named American Medical Association Alliance. By a vote of 229-88 at the annual convention in June, the AMA Auxiliary delegates voted to change the national name from auxiliary to alliance. The delegates also adopted the tag line "Physician spouses dedicated to the health of America," which

parallels the AMA's tag line "Physicians dedicated to the health of America." The name change will be phased in during the next year.

The ISMA Auxiliary delegates to the convention supported the name change with the endorsement of the ISMA Board of Trustees. The seven delegates representing Indiana were Trudy Urgena, president; Kay Enderle, immediate past president; Sue Greenlee, president-elect; Darlene Haddawi, first vice president; and Valerie Gates, Sue Schneider and

Patrick Walker, area vice presidents.

Recognizing ISMA Auxiliary leadership ability, the AMA Auxiliary has tapped Ann Wrenn from Bloomington and Rod Ashley from Marion, two former state presidents, for national positions.

Ann Wrenn, state president in 1988-89, is serving on the 1992-93 AMA Auxiliary Board of Directors as one of 10 national field directors. Elected and installed at the annual convention in June, Mrs. Wrenn said, "It is truly exciting to be asked to serve in this brand new national position, encouraging state and county auxiliaries to work as a team with their medical societies." Her territory includes Indiana, Ohio, Colorado, Rhode Island and West Virginia. She will provide field service as requested by the state presidents with emphasis on conducting workshops and focus groups and facilitating and assisting with program development.

Rod Ashley, 1990-91 state president, is serving on the AMA Auxiliary Membership Committee. The national organization has recognized four Indiana county medical auxiliaries for achieving the goal of a 10% increase in AMA Auxiliary membership for 1991-92: Elkhart, Lake, LaPorte and Porter. Delaware/Blackford, Owen/Monroe, Tippecanoe and Vanderburgh S.W. auxiliaries were recognized for increasing national membership, and Bartholomew/Brown, Noble/LaGrange, Wayne/Union and Wells county auxiliaries were recognized for maintaining national membership levels.

During her state report at the national convention, Kay Enderle, immediate past president, focused on the primary benefit of auxiliary membership: medical family support. She said, "The auxiliary



Representing Indiana at the American Medical Association Auxiliary convention in Chicago were, front, from left, Ann Wrenn, Sue Ellen Greenlee, Trudy Urgena and Kay Enderle, and back, from left, Valerie Gates, Darlene Haddawi, Pat Walker, Rosanna Iler and Sue Schneider.

■ auxiliary report

is a support group when needed. Auxilians rally to the aid of other auxilians in the time of medical family crisis."

The AMA Auxiliary recognized 16 Indiana county medical auxiliaries for their major contributions to the \$41,442.02 raised in Indiana for the American Medical Association Education and Research Foundation. Achievement Award Certificates were presented to the following counties during the annual convention:

Bartholomew/Brown, Dubois, Delaware/Blackford, Floyd, Howard, Indianapolis, Knox, LaPorte, Noble/LaGrange, Porter, St. Joseph, Tippecanoe, Vanderburgh S.W., Vigo, Wayne/Union and Wells. Indiana University School of Medicine will be the chief recipient of the \$41,442.02 raised by county medical auxiliaries this past year.

Upcoming auxiliary events
Medical Family Seminar – Sept. 23,

Radisson Hotel, Keystone at the Crossing, Indianapolis. Topics include: "Children in Affluent Families," "Sex, Passion and Intimacy" and "Stress and Impairment in the Medical Family."

ISMA Convention Spouse Program – Oct. 16, Westin Hotel, Indianapolis. Topic: "Crisis in the American Family."

Confluence I – Oct. 18-20, Chicago. □

■ drug names

Look-alike and sound-alike drug names

	SYNACORT	SENOKOT
Category:	Corticosteroid	Laxative
Brand name:	Synacort, Syntex	Senokot, Purdue Frederick
Generic name:	Hydrocortisone	Senna
Dosage forms:	Cream	Tablets, granules, syrup, suppositories
	DICLOXACILLIN	CLOXACILLIN
Category:	Penicillinase-resistant penicillin	Penicillinase-resistant penicillin
Brand name:	Dycill, SK-Beecham Dynapen, Apothecan Pathocil, Wyeth-Ayerst	Tegopen, Apothecan Cloxapen, SK-Beecham
Generic name:	Dicloxacillin sodium	Cloxacillin sodium
Dosage forms:	Capsules, powder for oral suspension	Capsules, powder for oral suspension

Benjamin Teplitsky, R. Ph.
Brooklyn, N.Y.

Look-alike and sound-alike drug names can be misinterpreted by a nurse reading doctors' orders or by a pharmacist compounding physicians' prescriptions.

Such misunderstandings can result in the administration of a drug not intended by the prescriber. Awareness of such look-alike and sound-alike drug names can reduce potential errors. □

CARDIOLOGY - DIAGNOSTIC & INTERVENTIONAL



NASSER, SMITH AND PINKERTON CARDIOLOGY, INC.

William K. Nasser, M.D.

Michael L. Smith, M.D.

Cass A. Pinkerton, M.D.

James W. VanTassel, M.D.

Dennis K. Dickos, M.D.

John D. Slack, M.D.

Charles M. Orr, M.D.

Jane Howard, M.D.

James H. Adlam, M.D.

V. Michael Bournique, M.D.

Frank J. Green, M.D.

Nancy A. Branyas, M.D.

Charles P. Taliercio, M.D.

Bruce F. Waller, M.D.

Thomas F. Peters, M.D.

Lawrence E. Gering, M.D.

providing

Cardiology & Cardiac Catheterization

Transesophageal Echocardiography

Doppler & Echocardiography

Exercise Stress Testing

Coronary Angioplasty

Nuclear Cardiology

Pacemaker Surveillance

Holter Monitoring

Percutaneous Valvuloplasty

Electrophysiology Testing

Coronary Atherectomy

Myocardial Biopsy

Automatic Implantable

Cardioverter Defibrillator

Signal Averaged Electrocardiography

Nutrition Services

Cardiac Rehabilitation

Office: 317-871-6666

1-800-732-1482

1-800-CHD-PTCA

1-800-CAD-PTCA

FAX: 317-871-6019

With additional offices

located in:

Anderson • Brazil

Carmel • Kokomo

Marion • Terre Haute

Suite 400

St. Vincent Professional Building

8402 Harcourt Road

Indianapolis, Indiana 46260

THE HEART CENTER OF INDIANA

CARDIOLOGY

FORT WAYNE CARDIOLOGY

Basil C. Genetos, M.D.
Robert W. Godley, M.D.
Michael J. Mirro, M.D.
Kevin J. Kelly, M.D.
Fred Doloresco, M.D.
John F. Phillips, M.D.
Patrick J. Daley, M.D.
William W. Wilson, M.D.
James J. Heger, M.D.
Raymond E. Dusman, M.D.
Charles F. Presti, M.D.
Stephen E. Brown, M.D.
David D. Whang, M.D.

Practice Limited to Cardiology
(Physician's Referral Only)

Locations nearby:

1912 Carew Street
Fort Wayne, Indiana 46805
(219) 482-4865 (800) 637-6505 (IN)
(800) 334-4371 (MI & OH)

Lutheran Medical Park
7900 W. Jefferson Blvd.
Suite 202
Fort Wayne, Indiana 46804
(219) 432-5613

Caring for people is the first priority at Fort Wayne Cardiology. Since 1978, our team approach has served referring physicians and their patients with the latest in heart care treatment and technologies.

Fort Wayne Cardiology is a trusted and caring group of people, featuring 13 board certified/board eligible cardiologists, as well as a special staff of nurses, technologists and administrative assistants. Patients are able to receive comprehensive cardiac services which include: cardiac catheterization, coronary angioplasty and atherectomy, electrophysiology, valvuloplasty, nuclear cardiology, doppler and echo cardiography, exercise stress testing, holter monitoring, ECG event monitoring, permanent pacemaker implantation and surveillance, non-invasive peripheral vascular evaluation, peripheral angioplasty and atherectomy, myocardial biopsy, transesophageal echo, AICD insertion and surveillance, signal average EKG, tilt table and rehab therapy.

University trained, certified cardiologists; the best in diagnostic equipment; clinical research and specialization within the specialty, makes Fort Wayne Cardiology an excellent center for heart care.

Satellite Clinics:

Angola	Kendallville	Defiance, OH
Auburn	LaGrange	Hicksville, OH
Columbia City	Wabash	
Huntington	Warsaw	

CARDIOLOGY

A new era in heart care has begun...

Now open



Robert E. Swint, Sr., M.D.

Mark A. Jones, M.D.

David A. Kaminskas, M.D.

Gary A. Hambel, M.D.

Mary H. Heintz, M.D.

Ravi N. Bathina, M.D.

Gregory C. Tomlinson, M.D.

Brian T. Lew, M.D.

Peter C. Hanley, M.D.

Christopher Zee-Cheng, M.D.

Steven W. Orlow, M.D.

David A. Belvedere, M.D.

Mark S. Hazen, M.D.

7836 W. Jefferson Blvd.

Fort Wayne, IN 46804

(219) 432-2297

800 Broadway, Suite 204

Fort Wayne, IN 46802

(219) 422-2558

3217 Lake Ave.

Fort Wayne, IN 46805

(219) 422-2297

2510 Dupont Rd.

Fort Wayne, IN 46825

(219) 489-8280

1-800-777-2297

CARDIOLOGY

Indiana Heart Physicians, Inc.

a member of the
Indianapolis Regional Heart Center
at St. Francis

Indianapolis/Beech Grove Medical Center
112 North 17th Avenue, Suite 300

Office	317-783-8800
Appointment Scheduling	317-781-3615
Cardiac Testing Center	317-781-3636
Toll Free (Nationwide)	800-992-2081

Consulting Offices at:

Greenwood
Shelbyville
Martinsville

Indiana Heart Physicians at Columbus
3154 North National Road, Suite C

Office	812-379-2020
Toll Free (Indiana)	800-331-4765

Physicians

H. O. Hickman, Jr., M.D., FACC
Thomas M. Mueller, M.D., FACC
J. Douglas Graham III, M.D., FACC
Kathleen H. Flohr, M.D., Ph.D., FACC
Jeffrey L. Christie, M.D., FACC
Stephen H. Kliman, M.D., FACC
Thomas C. Passo, M.D., FACC
Emily A. Diltz, M.D., FACC
John E. Batchelder, M.D., FACC
Mark D. Cohen, M.D., FACC
William J. Berg, M.D.
Thomas D. Hughes, D.O.
George E. Revtyak, M.D., FACC
Jeffrey Mossler, M.D.
Irwin Labin, M.D., FACC

at Columbus

David J. Hamilton, M.D., FACC
Kevin C. Preuss, M.D., FACC

providing

Cardiology and Cardiac
Catheterization
Coronary Angioplasty
Coronary Atherectomy
Electrophysiology
Percutaneous Valvuloplasty
Nuclear Cardiology
Stress Echocardiography
Exercise Stress Testing
Holter Monitoring
ECG Event Monitoring
Permanent Pacemaker Implantation
Pacemaker Surveillance
Color Flow Doppler Echocardiography
Laser Angioplasty
Trans-Telephonic Pacemaker Analysis

Noninvasive Peripheral
Vascular Evaluation
Signal Average EKG
Myocardial Biopsy
Tilt Table Testing

CARDIOLOGY



Indianapolis Cardiology Associates, Inc.

Robert E. Edmands, M.D., F.A.C.C.
Samuel M. Hazlett III, M.D.
Don B. Ziperman, M.D., F.A.C.C.
Bradley A. Weinberg, M.D.

are pleased to announce the association of
Richard A. Hahn, M.D.
for the practice of cardiology.

- Cardiology & Cardiac Catheterization
- Coronary Angioplasty
- Laser Angioplasty
- Coronary Atherectomy
- Echocardiography
- Transesophageal Echocardiography
- Color Flow Imaging

- Nuclear Cardiology
- Stress Testing
- Holter Monitoring
- Pacemaker Surveillance
- Permanent Pacemaker Implantation
- Evaluation of Cardiac Risk Factors
- Cardiac Rehabilitation Program

East Location

1400 N. Ritter Avenue, Suite 585
Indianapolis, Indiana 46219
Office~(317) 355-1500
Referring Physician Line~(317) 355-1100

North Location

7250 Clearvista Drive, Suite 227
Indianapolis, Indiana 46256
Office~(317) 841-5385
Referring Physician Line~(317) 841-5386

CARDIOLOGY

THE HEART CENTER OF MARION



Prakash N. Joshi, M.D., F.A.C.C.
Diplomate, American Board of
Internal Medicine & Cardiovascular
Diseases

providing
Cardiology
Electrocardiogram
Exercise Stress Testing
Doppler &
Echocardiography
Stress
Echocardiography
Holter Monitoring
in Internal Medicine

Subodh S. Gupte, M.D., F.A.C.C.
Diplomate, American Board of
Internal Medicine, Cardiovascular
Diseases and Advanced Achievement
in Internal Medicine

**703 Chapel Pike
Marion, Indiana 45952**

**Appointments: (317) 664-1201
Business Office: 1-800-345-2035
FAX: (317) 664-2866**

Nasser, Smith & Pinkerton Cardiology, Inc.

DOCTORS

These spaces are available.

For rates, write or call

**INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-4762.**

DOCTORS – This space is available.

For rates, write or call INDIANA MEDICINE,
322 Canal Walk, Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

DOCTORS – This space is available.

For rates, write or call INDIANA MEDICINE,
322 Canal Walk, Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

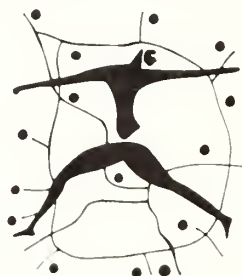
PLASTIC, RECONSTRUCTIVE & HAND SURGERY

One Call, Day or Night!

Our group is always available, 365 days a year, day or night; to see your patients in Indianapolis because there are times when your patient shouldn't have to wait.

ALSO SEEING PATIENTS
BY APPOINTMENT IN THESE
CENTRAL INDIANA CITIES:

BEECH GROVE
CRAWFORDSVILLE
DANVILLE
GREENCASTLE
GREENSBURG
KOKOMO
LEBANON
MOORESVILLE
SURGERY CENTER



SERVING 15 CENTRAL
INDIANA HOSPITALS

VISA, MASTERCARD ACCEPTED
FINANCING AVAILABLE

ZOLLMAN CENTER FOR PLASTIC & HAND SURGERY

7439 Woodland Drive, Indianapolis, IN 46278



Member, American Society
of Plastic and Reconstructive Surgeons

317-328-1100

1-800-332-3943

FAX: 317-328-6948

Wally Zollman M.D., F.A.C.S., Twatchai Yamcharern M.D., F.A.C.S., Richard S. Troiano M.D., F.A.C.S.

PLASTIC SURGERY

MERIDIAN PLASTIC SURGERY CENTER

For information on services
317/575-0110
or 800/352-7849
106th & Meridian Streets
Indianapolis



An Ambulatory Surgery Center
Exclusively for Cosmetic, Plastic
and Reconstructive Surgery

Board-Certified Physicians

- Stephen W. Perkins, M.D., F.A.C.S.
- William R. Nunery, M.D., F.A.C.S.
- Ronald T. Martin, M.D.
- A. Michael Sadove, M.D., F.A.C.S.
- Barbara Siwy, M.D.

Facial, Ophthalmic & General
Plastic Surgery • Anesthesiology

Licensed by the Indiana State
Board of Health • Medicare
Certified

PLASTIC SURGERY



AMERICAN SOCIETY OF
PLASTIC & RECONSTRUCTIVE
SURGEONS, INC.

John G. Pantzer Jr., M.D., F.A.C.S.
Diplomate, American Board
of Plastic Surgery

1801 North Senate Blvd., Suite 735
Indianapolis, Indiana 46202
317-929-5500

RADIOLOGY

SUPERB QUALITY DIAGNOSTIC RADIOLOGY AND RADIATION ONCOLOGY SERVICES ARE ONLY A TELEPHONE CALL AWAY...

Our mission is to provide caring, high quality, state-of-the-art imaging, interventional, and radiation oncological services to our patients, referring clinicians, and institutions. Call us today to discuss your unique requirements or to refer your patients for prompt, courteous, cost effective, and professional service.

INDIANAPOLIS

Methodist Hospital
1701 N. Senate Avenue
Methodist Professional Center
1801 North Senate Avenue
(317) 929-3580

Methodist Hospital Breast Cancer
Screening Program
(317) 929-5000

Eagle Highlands Radiologic Services
6920 Parkdale Place
Suite 111
(317) 291-4411

Lakeview Radiologic Services
9002 North Meridian Street
Suite 110
(317) 844-6944

BROWNSBURG

Brownsburg Radiologic Services
1375 North Green Street
Suite 200
(317) 852-3222

COLUMBUS

(Radiation oncology only)
Bartholomew County Hospital
2400 East Seventeenth Street
(812) 376-5361

CRAWFORDSVILLE

Culver Union Hospital
1710 Lafayette Road
(317) 364-3146

GREENSBURG

Decatur County Memorial Hospital
720 North Lincoln Street
(812) 663-1156

KOKOMO

(Radiation oncology only)
Howard Community Hospital
3500 South Lafountain Street
(317) 453-8189

TERRE HAUTE

(Radiation oncology only)
Union Hospital
1606 North Seventh Street
(812) 238-7504



RADIOLOGIC SPECIALISTS OF INDIANA, INC.
All Physicians Board Certified.



CLINICAL & ANATOMIC PATHOLOGY

The Medical Laboratory

of Drs. Thornton-Haymond-Costin-Buehl-Bolinger-Warner-McGovern-McClure-Hooker-Winkler
5940 West Raymond Street • Indianapolis, Indiana 46241

CHEMISTRY
MICROBIOLOGY
HEMATOLOGY
TOXICOLOGY
CYTOLOGY
HISTOLOGY
CUSTOMER SERVICE



Courier Service
24 hr. Pathology Consultation
Assignment Accepted: Medicare/Medicaid
BC/BS VIP and PC/USA, Preferred Care, Prucare
18 Convenient Branch Locations

CENTRAL TESTING FACILITY: 5940 W. Raymond St., Indianapolis, IN 46241
Phone: 317/248-2448

"Here Today To Serve You Tomorrow."

DOCTORS

This space is available.

For rates, write or call
INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

PULMONARY DISEASE

RESPIRATORY CONSULTANTS OF INDIANA

DAVID B. COOK, M.D., FCCP
CHRIS C. NAUM, M.D.

MICHAEL R. NIEMEIER, M.D., FCCP
THOMAS Y. SULLIVAN, M.D.
JOHN A. WARDEN, M.D., FCCP

ROBERT W. WELLER, M.D., FCCP
PATRICK E. WRIGHT, M.D., FCCP

Pulmonary Disease

Lung and lung-heart transplantation
Laser Bronchoscopy
Intra-bronchial radiation therapy
Trans-tracheal oxygen therapy
Complete rest and exercise
physiologic testing

Critical Care

Physicians ABIM certified in
critical care 24 hours/day
State-of-the-art eighty bed
intensive care facility

Hyperbaric Medicine

Diagnostic assessment
of local oxygen delivery
Treatment of disorders of
regional O₂ delivery and
utilization

Sleep Disorders

Clinical polysomnographer
Full-service polysomnography
laboratory

1801 N. SENATE BLVD., SUITE 400, INDIANAPOLIS, IN 46202 • OFFICE (317) 929-5820 • FAX (317) 929-3916
6920 PARKDALE PLACE, SUITE 215 • INDIANAPOLIS, IN 46254 • OFFICE (317) 328-6635 • FAX (317) 328-6640
GREENSBURG (812) 653-5533 • LEBANON (317) 873-2103 • RUSHVILLE (317) 932-4111 • TERRE HAUTE (812) 232-0564
AFTER HOURS: ANSWERING SERVICE (317) 926-3466 OR 1-800-772-7788

1-800-321-LUNG • MONDAY - FRIDAY 8:30 A.M. - 4:30 P.M.

ALCOHOLISM TREATMENT

Eugene G. Roach, M.D.
Executive/Medical Director



Anderson Center
of Saint John's
221 1/2 Jackson Street
Anderson, Indiana 46016

1-800-435-9143 or (317) 646-8383

- Comprehensive Alcohol and Drug Treatment
- Separate Programs for Adolescents and Adults
- Free Assessment and Intervention

DOCTORS

This space is available.

For rates, write or call

INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

■ physicians' directory

INTERNAL MEDICINE

NEPHROLOGY & INTERNAL MEDICINE, INC.

Thomas Wm. Alley, M.D., FACP	Douglas F. Johnstone, M.D.
George W. Applegate, M.D.	Wendy L. Kindig, M.D.
Richard Bloch, M.D.	LeRoy H. King, Jr., M.D. FACP
Charles B. Carter, M.D.	Barry F. Kriebel, M.D.
William H. Dick, M.D., FACP	Mary A. Margolis, M.D.
Theodore F. Hegeman, M.D.	Tim E. Taber, M.D.

**1801 N. Senate Blvd., Suite 355
Indianapolis, 46202
Tel: 317-924-8425**

By Physician Referral

Clinical Nephrology, Hemodialysis, Peritoneal Dialysis, Renal Transplantation, Metabolic Kidney Stone Disease, Hypertension, Fluid and Electrolyte Imbalance, Critical Care

HEMODIALYSIS

CHRONIC MAINTENANCE OUTPATIENT HEMODIALYSIS

DIALYSIS INSTITUTE OF ANDERSON
2629 Nichol Avenue
Anderson, Indiana 46011
317-649-0772

DIALYSIS INSTITUTE OF BEECH GROVE
3834 South Emerson Avenue
Indianapolis, Indiana 46203
317-787-3171

For further information contact
NEPHROLOGY & INTERNAL MEDICINE, INC.
1801 N. Senate Blvd., Suite #355
Indianapolis, Indiana 46202
317-924-8425

Outpatient renal consultation may be scheduled at any location.

HAND SURGERY

JOHN C. KLEIN, M.D.

Specializing in the diagnosis and treatment of hand, wrist, and forearm disorders.

2727 N. Pennsylvania St. 317-925-1665
Indianapolis, IN 46205 Answered 24 hours

Diplomate American Board of Orthopedic Surgery
with certificate of added qualifications in surgery of the hand.

HAND SURGERY

SOUTH INDY HAND CENTER, P.C. **VIDYASAGAR S. TUMULURI, M.D., F.A.C.S.** CERTIFIED IN HAND SURGERY

Practicing hand and wrist surgery

South Sherman Professional Complex
3417 S. Sherman Dr., Suite F
Beech Grove, IN 46107
(317) 783-1319

Community Hospital South Prof. Bldg
1550 E. County Line Rd., Suite 315
Indianapolis, IN 46227
(317) 888-0004

DERMATOPATHOLOGY

DERMATOPATHOLOGY LABORATORY

Larry J. Buckel, M.D.
Robert M. Hurwitz, M.D.

Howard R. Gray, M.D.
William B. Moores, M.D.



Diplomates of the American Boards
of
Dermatology and Dermatopathology

Specializing in
Inflammatory Skin Diseases
and
Neoplasms of the Skin

9202 North Meridian Street
Suite 215

Approved for and Accept
Medicare and Medicaid
Assignment

Indianapolis, Ind. 46260
(317) 843-2204

UPS Mailers and Courier Service Available

PSYCHIATRY

Eugene G. Roach, M.D.
Executive/Medical Director



Anderson Center

of Saint John's
2210 Jackson Street
Anderson, Indiana 46016

1-800-435-9143 or (317) 646-8114

- Comprehensive Psychiatric Treatment
- Separate Programs for Adolescents, Adults and Older Adults
- Program for Dual Diagnosis

NEUROLOGY

Shirley M. Mueller, M.D.
General Neurology

*Practice Dedicated Toward Problems Associated With
Numbness-Weakness-Dizziness And Pain Including Headache*

Testing Available

*North: St. Vincent's Professional Bldg., Suite 726, Indianapolis
Tuesday, Thursday & Friday • 317-871-6000*

*South: Community South Professional Bldg., Suite M, Indianapolis
Monday & Wednesday • 317-887-7790*

PERIPHERAL VASCULAR SURGERY



VASCULAR SURGERY, P.C.

Vascular
Diagnostics
— Mobile
— Non-invasive
— Testing™

Malcolm B. Herring, M.D.
Daniel R. LeGrand, M.D.
David L. Madison, M.D.
Sajjad M. Hussain, M.D.

St. Vincent Professional Building
8402 Harcourt Road
Suite 613
Indianapolis, Indiana 46260
Telephone (317) 871-6400
TOLL FREE (800) 336-6413

Carmel Medical Center
13450 North Meridian Street
Suite 160
Carmel, Indiana 46032
Telephone (317) 581-6020



The Vascular Lab

NONINVASIVE VASCULAR TESTING

The vascular lab offers a full spectrum of diagnostic vascular testing services, including the new addition of color computed sonography, supported by the entire team of:

John F. Ansbro, M.D. • Alan T. Marty, M.D. • H. Dan Adams, M.D.
Richard A. Murrell, M.D. • Daniel B. Daniels, M.D. • Jay Tuna, M.D.

Cardiovascular Surgery Inc.

350 West Columbia
Suite 350
Evansville, Indiana 47710
812-423-2395

■physicians' directory

ASTHMA & ALLERGY

FRANK WU, M.D.



DIPLOMATE,
AMERICAN BOARD
OF ALLERGY &
IMMUNOLOGY

St. Vincent Professional Building
8402 Harcourt Road, Suite 606
Indianapolis, Indiana 46260
(317) 872-4213

ORTHOPAEDIC SURGERY

JAMES L. KAISER, M.D.



5626 E 16
82nd & Shadeland
If No Answer Call

- ORTHOPAEDIC SURGERY
- FRACTURES
- BACK SURGERY
- FOOT SURGERY
- ARTHROSCOPIC SURGERY

Certified American Board
Of Orthopaedic Surgery

5626 East 16th Street
Indianapolis, IN 46218

(317) 352-0176

OFFICE ANSWERS DAY & NIGHT

352-0176
352-0176
543-6089

ONCOLOGY



Oncology Associates

Michael A. Cross, M.D.

Board Certified, Radiology (Therapeutic)

John R. Pancoast, M.D.

Board Certified, Internal Medicine
and Medical Oncology/Hematology

John F. Sacco, M.D.

Board Certified, Internal Medicine
and Radiology (Therapeutic)

Offering comprehensive cancer care, including:

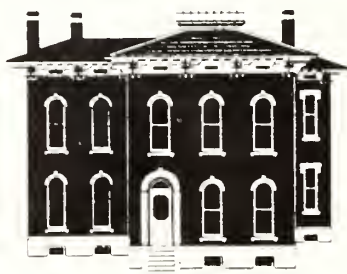
- Cancer Detection
- Chemotherapy
- Radiation Therapy (Linear Accelerator)
- Biologic Therapy
- Education and Support Services
- Hospital, Home and Hospice Care

Dearborn County Hospital Professional Building
606 Wilson Creek Road, Suite 130
Lawrenceburg, Indiana 47025
(812) 537-1911

Oncology Associates' 16 physician members have additional offices in Cincinnati, Montgomery and Middletown, Ohio; and Crestview Hills, Kentucky. The practice offers outpatient care and clinics in 11 hospitals throughout the Tri-State area.

ONCOLOGY — HEMATOLOGY

INDIANA ONCOLOGY HEMATOLOGY CONSULTANTS



1-800-ONC-HEME
1-800-662-4363

Central: 317-927-5770
St. Francis: 317-783-8509

ADULT ONCOLOGY HEMATOLOGY — CENTRAL OFFICE

1828 N. Illinois Street Indianapolis, IN 46202 927-5770

Laurence H. Bates, M.D.

Gregory W. Smith, M.D.

William M. Dugan, Jr., M.D.

William H. Bond, M.D.

Redmond P. Hogan, III, M.D.

PEDIATRIC ONCOLOGY HEMATOLOGY — CENTRAL OFFICE

1828 N. Illinois Street Indianapolis, IN 46202 927-5770

Arthur J. Provisor, M.D.

Deborah S. Provisor, M.D.

ADULT ONCOLOGY HEMATOLOGY — ST. FRANCIS OFFICE

1600 Albany — Medical Clinic Bldg. Beech Grove, IN 46107 783-8509

Redmond P. Hogan, III, M.D.

Randall C. Trowbridge, M.D.

Gregory W. Smith, M.D.

*Central Office Located in the Byram Gates Middleton House
Listed on the National Register of Historic Places*

RADIATION ONCOLOGY



Physicians:
ROGER ROBISON
TAE CHUNG

Radiation Oncology Services for Southwest Indiana

VINCENNES
Good Samaritan Hospital
(812) 885-3939

TERRE HAUTE
Regional Hospital
(812) 237-9326

ROGER ROBISON, M.D., F.A.C.P.
M.D. Anderson, 1980
Certified: Radiation
Oncology
Medical Oncology

TAE CHUNG, M.D.
Chicago Hines, V.A., 1976
Certified: Radiation
Oncology

RADIATION ONCOLOGY

TRI-STATE RADIATION ONCOLOGY

Evansville Cancer Center
Evansville, Indiana
(812) 474-1110



Welborn Cancer Center
Evansville, Indiana
(812) 426-8373

AL KORBA, M.D.; ALY RAZEK, M.D.
SHANNON LAMB, M.D.; PRAMOD V. PRABHU, M.D.

★ ★ ★ ★ ★

Tri-County Cancer Care Center
Jasper, Indiana
(812) 482-2212

DEVIDAS SHETH, M.D.

Tri-County Cancer Care Center
Princeton, Indiana
(812) 386-6663

MOISES DOMINGO, M.D.

★ ★ ★ ★ ★

Olney Cancer Center
Olney, Illinois
(618) 392-3050

MOISES DOMINGO, M.D.

Harrisburg Oncology Associates
Harrisburg, Illinois
(618) 252-5126

MANJU GUPTA, M.D.

★ ★ ★ ★ ★

Radiation Oncology
Owensboro, Kentucky
(502) 926-7228

TRISTAN BRIONES, M.D.

Henderson Cancer Center
Henderson, Kentucky
(502) 827-0255

PRAMOD V. PRABHU, M.D.

★ ★ ★ ★ ★

In Indiana 1-800-843-7117 • Out of Indiana 1-800-331-9294
24-hour answering service (812) 476-1367

TRANSPLANTATION

*Transplantation offers patients
with end-stage organ disease their only
opportunity for true rehabilitation...*

Methodist Transplant Center
24-hour referral: 800 772-7788



The Difference is Experience

P.O. Box 1367
1701 N. Senate Blvd.
Indianapolis, Indiana 46206

Heart Transplantation

Surgical Director: **Harold Halbrook, M.D.**

Surgeons: John Fehrenbacher, M.D.,
Daniel Beckman, M.D., David Hormuth, M.D.
Program Cardiologist: Douglas Pitts, M.D.

Kidney Transplantation Pancreas Transplantation

Surgical Director: **Brian Haag, M.D.**

Surgeons: Larry Stevens, M.D.,
Dale A. Rouch, M.D.
Program Nephrologist: Charles Carter, M.D.

Lung Transplantation

Surgical Director: **Harold Halbrook, M.D.**

Surgeons: John Fehrenbacher, M.D.,
Daniel Beckman, M.D., David Hormuth, M.D.
Program Pulmonologist:
Michael Niemeier, M.D.

Liver Transplantation

Surgical Director: **Dale A. Rouch, M.D.**

Surgeons: Larry Stevens, M.D.,
Brian Haag, M.D.
Program Pediatric Gastroenterologist:
Susan Maisel, M.D.
Program Hepatologist: Stephen C. Pappas, M.D.

Bone Marrow Transplantation

Co-Director: Luke Akard, M.D.

Co-Director: Jan Jansen, M.D., Ph.D.

Corneal Transplantation

Surgical Director: **Stephen Johnson, M.D.**

Tissue/Bone Bank

Surgical Director: **David A. Fisher, M.D.**

ORTHOPAEDIC SURGERY

TRADITION



ORTHOPAEDICS INDIANAPOLIS

*"CELEBRATING THREE DECADES
OF ORTHOPAEDIC EXCELLENCE"*

DONALD S. BLACKWELL, M.D.
F.R. BRUECKMANN, M.D., F.A.C.S.
ANTHONY R. LASICH, M.D.
WILLIAM O. IRVINE, M.D.
JOSEPH C. RANDOLPH, M.D.
DONALD E. RUSSELL, M.D.
MARK R. STEVENS, M.D.
TERRY R. TRAMMELL, M.D.
ANDREW J. VICAR, M.D.
VINCENT L. FRAGOMENI, M.D.
JOHN K. SCHNEIDER, M.D.
JOSEPH R. BAELE, M.D.
SANFORD S. KUNKEL, M.D.
DAVID A. FISHER, M.D.
D. KEVIN SCHEID, M.D.
MICHAEL F. COSCIA, M.D.
DEAN C. MAAR, M.D.
DAVID S. BROKAW, M.D.
HENRY G. STEIN, M.D., F.A.C.S.
ORTHOPAEDIC SURGEONS
ROBERT C. GREGORI, M.D.
PHYSICAL MEDICINE & REHABILITATION

JOINT RECONSTRUCTION
TRAUMA
FRACTURE CARE
SPORTS MEDICINE
SCOLIOSIS
SPINAL SURGERY
SHOULDER SURGERY
HAND SURGERY
FOOT SURGERY
ARTHROSCOPIC SURGERY
PEDIATRIC ORTHOPAEDICS
ADULT ORTHOPAEDICS
ILIZAROV LIMB LENGTHENING
& DEFORMITY CORRECTION

ORTHOPAEDICS INDIANAPOLIS
1801 N. SENATE, SUITE 200
INDIANAPOLIS, IN 46202
317-923-5352
1-800-223-3381
FAX: 317-924-0115
INDIANAPOLIS •
ZIONSVILLE • DANVILLE
SPEEDWAY • GREENCASTLE

ORTHOPAEDICS & SPORTS MEDICINE

Hoosier Orthopaedics & Sports Medicine, P.C.

Total Joint Replacement
Athletic Injuries and Sports Medicine
Arthroscopic Surgery
Pediatric and Adult Orthopaedics
Fracture Care/Trauma

Reconstructive Surgery of the Foot and Ankle
Reconstructive Surgery of the Shoulder or Knee
Back Surgery
General Orthopaedics

Office Answers Day and Night

13450 North Meridian Street, Suite 355, Carmel, Indiana 46032
(317) 575-2705

8330 Naab Road, Suite 234, Indianapolis, Indiana 46260
(317) 870-7075



Robert T. Clayton, M.D.

Robert E. Cravens, M.D.

John E. Garber, M.D.

Robert M. Palmer, M.D.

Frank B. Throop, M.D.

Thomas F. Trainer, M.D.

COMPREHENSIVE REHABILITATION

We're Working to Make Life Better

At Kokomo Rehabilitation Hospital, we're committed to only one specialized field – rehabilitation medicine.

This central focus means your patients receive the therapy and care needed to restore their lives to the fullest extent possible.



Kokomo Rehabilitation Hospital

Our newly opened, 60-bed hospital features sophisticated high-tech equipment, a total barrier-free environment and highly trained therapists.

Give us a try. Your patients and you will be pleased with the results.

– William J. Lester, MD,
Medical Director

Bringing the Quality Back to Life for Patients Affected by:

Stroke • Traumatic Brain Injury • Spinal Cord Injury • Amputation • Orthopedic Disorders • Neurological Disorders • Arthritis • Back and Neck Injuries • Chronic Pain • Multiple Trauma • Return to Work
• Carpal Tunnel Syndrome and other Cumulative Trauma Disorders

829 Dixon Road • Kokomo, Indiana 46901
General Hospital Information
(317) 452-6700

For Referral or Admission Information
1-800-886-LIFE

A Continental Medical Systems Facility

DOCTORS

This space is available.

For rates, write or call
INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

MULTI-SPECIALTY GROUP PRACTICE

Addictionology
Allergy
Cardiovascular Diseases
Dermatology
Endocrinology
Family Practice
Gastroenterology
Gynecology
Hematology-Oncology
Internal Medicine
Neurology
Nephrology
Nuclear Medicine
Obstetrics
Ophthalmology
Orthopedics
Otolaryngology
Pediatrics
Psychiatry
Pulmonary Medicine
Rheumatology
Surgery
Urology



**Welborn
Clinic**

421 Chestnut Street
Evansville, Indiana 47713
(812)426-9440

Toll-free in Indiana:
1-800-521-0269

Westside Family Practice Ctr.
(812)429-1818

Welborn Clinic East
(812)474-7123

Welborn Clinic Highland
(812)426-9565

In Newburgh:
Welborn Clinic Newburgh
(812)853-7391

In Reo:
Reo Family Practice Center
(812)649-5061

■ from the museum

Physicians, dentists and other medical practitioners predominantly favored the toothkey as the instrument to extract teeth during the 1700s and early 1800s.

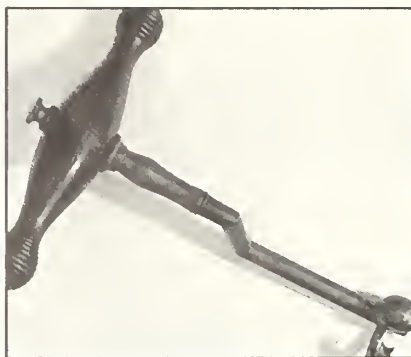
The toothkey acquired its name from its shape and style. Similar to a door key, the instrument had a straight shaft that contained a large ring handle on one end.

The other end contained a hinged claw that attached under a bolster. After placing the bolster against the root of the tooth and engaging the claw over the tooth's crown, the operator turned the instrument in the same manner that a person turns a key in a lock. The rapid movement dislocated the tooth.

The use of the toothkey created problems for medical practitioners and patients. In *Surgical Essays* (1771), John Aitken (1740?-1790) noted that the toothkey's main defects included the oblique direction in which the instrument drew the tooth and the severe bruising of the gum the toothkey often caused.

Several adaptations to the instrument's original design increased its use and popularity. During the middle 1700s, Alexander Monro (1697-1767) replaced the metallic ring handle with a traverse ovoid handle made of wood – frequently ebony – or ivory.

This change and subsequent handle improvements enabled physicians, dentists and other medical practitioners to better grasp the instrument. By the end of the 1700s, the handle for the typical toothkey included a central section with cross-hatches and two ends that were smoothly waisted.



Physicians and dentists used a toothkey to extract teeth during the 1700s and early 1800s.

Besides the handle, the shaft and the bolster also underwent modifications during the 1700s. By 1765, the straight shaft of the toothkey acquired a slight curve and, by 1780, the shaft had the distinct bend required to prevent unnecessary force against adjacent teeth.

The versatility of the instrument increased when Robert Clarke (1767-1798) modified the shaft to include a second, right-angled bend, allowing the shaft to cross the mouth to the further jaw. Adaptations to the claw also increased versatility by enabling physicians and dentists to use a spring catch to fix the claw into different positions.

Improvements to the bolster and changes in bolster's use also increased the appeal of the toothkey to medical practitioners. According to an instrument catalog issued in 1795, Savigny, a manufacturer of dental equipment, produced a toothkey that contained a circular bolster. This improvement in the bolster's depth allowed the operator to extract teeth in the desired perpendicular direction.

Besides the shape of the bolster, changes occurred in its use. Benjamin Bell (1749-1806) suggested that operators wrap the bolster in linen before using the toothkey to reduce pressure on the tooth to be extracted.

Later, medical instructors stressed that physicians and dentists should use chamois leather instead of linen to wrap the bolster. By 1819, medical practitioners also used silk thread to fix pieces of cork to a concave bolster to reduce the pressure caused by the toothkey.

Other modifications to the toothkey included the addition of an auxiliary bolster, enabling physicians and dentists to brace the instrument against a tooth other than the tooth to be extracted. By 1848, Joseph Linderer (1809-1879) introduced a moveable bolster that operators could push along the shaft when the fulcrum was not needed opposite the claw.

Despite its improvements, the toothkey still created problems, such as breaking instead of extracting the tooth, lacerating the gum tissues or fracturing the jaw. By the middle 1800s, the refined design of dental forceps and the improvement of dental procedures caused a decline in the toothkey's use.

The Indiana Medical History Museum in Indianapolis will open an exhibit on the history of dentistry in October. Visitors may access the museum, located on the grounds of Central State Hospital, from the museum's entrance at 3045 W. Vermont St. □

Sources: *Antique Dental Instruments* (1986) by Elisabeth Bennion and *The Dental Office: A Pictorial History* (1984) by Richard A. Glenner, D.D.S.

CHILD NEUROLOGY

PEDIATRIC EEG

EVALUATION OF APNEA IN INFANTS

8902 North Meridian Street
Indianapolis, Indiana 46260



BRADFORD R. HALE, M.D.
MALAVALLI SEETHARAM, M.D.

Patient Phone
317-843-0286
Physician's Phone
317-843-0343 317-843-0320

RVU x GAF x CF = ?

AMS can now provide solutions to your new MEDICARE - RBRVU problems

- * Quick, computerized, custom-designed coding conversions
- * Pre-printed, custom-coded SUPERBILLS for your office use
- * Identification of the new CPT/EM/EV codes for your practice
- * Calculation of your modifiers, GPCIs, RVU/AHPB based fees
- * Electronic processing of claims to our ALL-PAYOR network

AMERICAN MEDICAL SERVICES
1099 N. Meridian Street * Suite 630
Indianapolis, IN 46204

For more information,
please call
(317) 630-3697

■ cme calendar

Indpls. Regional Heart Center
The Indianapolis Regional Heart Center will sponsor these courses:

- Sept. 17 - CCU Office-Based Cardiology Refresher Course.
- Sept. 17 - Cardiology Grand Rounds: Athletes and Heart Disease, Morgan County Memorial Hospital.
- Oct. 15 - CCU Cardiology Refresher Course.
- Oct. 31 - Concepts in Critical Care Conference, The Westin Hotel, Indianapolis.
- Nov. 19 - CCU Refresher Course.

All conferences will be held at the Indianapolis Regional Heart Center at St. Francis Hospital in Indianapolis unless otherwise listed. For details, call Marsha Breen, (317) 783-2776.

Reid Hospital

Reid Hospital and Health Care Services in Richmond will sponsor this CME course:

- Oct. 27 - Stroke Prevention and Management, Reid Hospital and Health Care Services, Richmond.

For more information, call Marie Hooper, (317) 983-3112.

Indiana University

The Indiana University School of Medicine will sponsor these courses:

- Sept. 19 - Glaucoma Update, University Place Conference Center, Indianapolis.
- Sept. 21-23 - Clinical Application of Echocardiographic Techniques, co-sponsored by American College of Cardiology, University Place

Conference Center, Indianapolis.

- Sept. 25-26 - Cardiology Update: Ischemic Heart Disease for the Internist, Krannert Institute, Indianapolis.

- Sept. 28-30 - Neonatal Nutrition Conference, University Place Conference Center, Indianapolis.

- Oct. 1 - Gastroenterology Update, University Place Conference Center, Indianapolis.

- Oct. 9 - Anxiety and Depression in the Elderly, University Place Conference Center, Indianapolis.

- Oct. 9-10 - Family Practice Update in Cardiology, Krannert Institute, Indianapolis.

- Oct. 23-24 - Ethics in Medicine, University Place Conference Center, Indianapolis.

- Nov. 2 - Third Annual Comprehensive Transthoracic and Transabdominal Fine Needle Aspiration Biopsy Cytology, University Place Conference Center, Indianapolis.

- Nov. 11-13 - Electrical Management of Cardiac Arrhythmias, Radisson Plaza Hotel, Indianapolis.

For more information, call (317) 274-8353.

St. Mary's Medical Center

St. Mary's Medical Center in Evansville will sponsor The Oncology Seminar: The Chess Game of Cancer Sept. 17 at Tri-State Hematology Oncology Consultants in Evansville.

For more information, call

(812) 479-4468.

Community Hospitals

Community Hospitals Indianapolis will sponsor the Third Annual Cardiovascular Symposium: Management Strategies for Primary Care Practitioners Sept. 19 at the Radisson Plaza Hotel in Indianapolis. For more information, call Donna Grahn, (317) 355-5714.

St. Vincent Hospital

St. Vincent Hospital and Health Care Center in Indianapolis will sponsor these CME courses:

- Sept. 25-27 - Psychodrama Workshop: Psychodramatic Role Training, Action Methods Training Center, Carmel.

- Oct. 2 - Arthur B. Richter Lectureship in Clinical Cardiology, Westin Hotel, Indianapolis.

For details, call Beth Hartauer, (317) 871-3460.

Methodist Hospital of Indiana
Methodist Hospital of Indiana will sponsor this CME course:

- Oct. 1-2 - Ochsner Lecture - Head & Neck Imaging, Methodist Hospital, Main Radiology Classroom, Indianapolis.

For details, call Gonzalo Chua, M.D., (317) 929-8210.

Union Hospital - Terre Haute

Union Hospital will sponsor the Fourth Annual Cardiovascular Symposium Sept. 19 at the Holiday Inn in Terre Haute.

Kenneth H. Cooper, M.D., chairman of the Cooper Clinic in Dallas, will be the guest speaker.

For details, call Brenda Fischer at (812) 238-7306. □

IU to sponsor CME program on health care reform

Health care reform will be the topic of a day-long continuing medical education symposium set for Oct. 24 at the University Place Conference Center in Indianapolis.

The symposium, "Balancing Costs, Care and Compassion: The Dilemmas of Health Care Reform," is designed to explore the crucial economic and moral issues that confront society in the quest for health care reform. It will feature presentations on key issues, a case study of an ethical dilemma and a discussion of current options for reform. Options to be considered include the Canadian health system, managed competition, the "pay or play" model, various state plans and federal initiatives.

Speakers will include the following: Marcia Angell, M.D., executive director of the *New England Journal of Medicine*; Brian Biles, U.S. House Ways and Means Committee Subcommittee on Health; Jane Fulton, Ph.D., University of Ottawa; Eli Ginzberg, Ph.D., Columbia University; Nancy Jecker, Ph.D., and Cindy Madden, Ph.D., University of Washington; Richard Kromick, Ph.D., University of California at San Diego; Donna Leff, Ph.D., Medill School of Journalism, Northwestern University; the Hon. Robert Muir Jr., New Jersey; Donald Murphy, M.D., Presbyterian-St. Luke's Hospital, Denver; Mark Siegler, M.D., director of the Center for Clinical Medical Ethics at the University of Chicago, Pritzker School of Medicine; and Woodrow Myers, M.D., former Indiana and New York City

health commissioner, now with The Associated Group in Indianapolis.

Faculty members from Indiana University will be Deborah Allen, M.D., and Gregory Gramelspacher, M.D., School of Medicine; Roger Dworkin, J.D., and David Smith, Ph.D., Poynter Center for the Study of Ethics and American Institutions; and Deborah Freund, Ph.D., director of the Bowen Research Center.

Sponsors of the event are the Indiana University Medical Center, the Bowen Research Center, the Poynter Center for the Study of Ethics and American Institutions and the Program in Medical Ethics. The registration fee for physicians is \$100.

A town meeting open to the public will be held Friday, Oct. 23, in the University Place Conference Center. The topic will be "Does Indiana Have a Health Care Crisis?"

For more information, call the IU School of Medicine Continuing Medical Education office, (317) 274-8353.

Joslin diabetes education program earns recognition

The Joslin Diabetes Clinic at Methodist Hospital in Indianapolis is one of 230 diabetes education programs in the United States to be recognized by the American Diabetes Association. Only those programs meeting stringent ADA criteria earn the recognition.

Joslin educational programs include classes on nutrition, disease management, diabetes and pregnancy and updates for insulin users. The clinic also holds monthly support groups for diabetic patients.

Cancer Society to sponsor annual oncology workshop

The American Cancer Society will sponsor its 17th annual Midwest Oncology Workshop Friday, Oct. 23, at the Westin Hotel in downtown Indianapolis. "Cancer Care ... Making the Transition" is the theme of the workshop, designed for health care professionals.

Speakers will be Joyce Yasko, Ph.D., and Harold Freeman, M.D. Topics will include serving the socioeconomically deprived, health insurance/reimbursement issues, AIDS and the future of health care.

The fee is \$45. For more information, call the American Cancer Society, P.O. Box 78038, Indianapolis, IN 46268, (317) 879-4100.

Evansville's Vascular Lab earns accreditation

The Vascular Lab of Cardiovascular Surgery in Evansville has been awarded a three-year accreditation by the Intersocietal Commission for Accreditation of Vascular Labs. The honor was based on outside review of its quality of care based on national standards of excellence in vascular testing.

The Vascular Lab is one of 72 labs accredited nationally.

MRI conference scheduled

The Center for Diagnostic Imaging of Indianapolis will host its annual MRI Conference Saturday, Sept. 19, at the University Place Conference Center in Indianapolis.

There is no charge to attend. For more information, call Tammy Hornung, (317) 846-0717 or 1-800-537-0005. □

■ obituaries

Clarence C. Atkins, M.D.

Dr. Atkins, 93, a retired Rushville otolaryngologist, died June 7 at Miller's Merry Manor in Rushville.

He was a 1923 graduate of the Indiana University School of Medicine and a U.S. Army veteran of World War I.

Dr. Atkins opened his practice in Rushville in 1925. He was a past president of the Rushville Rotary Club and a founder of the Rushville Boys Club. In 1943 he received the Golden Boy Award from the Boys Club of America. He owned a tree farm in Decatur County, Our Heritage Tree Farm, which was named the best tree farm in Indiana in 1972 by the *Louisville Courier Journal*.

Earl W. Bailey, M.D.

Dr. Bailey, 85, a retired Logansport general surgeon, died June 22.

He was a 1933 graduate of the University of Cincinnati College of Medicine and served in the Army Medical Corps during World War II.

Dr. Bailey was a past president of the Cass County Medical Society and had been a delegate to the Indiana State Medical Association. He served as vice president of the 11th District of the ISMA and served on the advisory committee for Logansport State Hospital. He retired in 1975.

Rudolf L. Boha, M.D.

Dr. Boha, 57, a Floyds Knobs general practitioner, died May 7 in Fort Myers, Fla.

He was a 1962 graduate of the Indiana University School of Medicine.

Dr. Boha was a past president of the Floyd Memorial Hospital medical staff.

Howard B. Brenner, M.D.

Dr. Brenner, 63, a Munster obstetrician/gynecologist, died June 12.

He was a 1953 graduate of the University of Illinois College of Medicine.

Dr. Brenner was the current president of the Lake County Medical Society. He was a founder of Community Hospital in Munster and served as the hospital corporation's first president. He was the first obstetrician/gynecologist at the Hammond Clinic when he started practicing in northwest Indiana in 1960. He was a fellow of the American College of Obstetricians and Gynecologists and the American College of Surgeons. In 1989 he was a plaintiff in a lawsuit against Community Hospital's directors, alleging fiscal mismanagement; the lawsuit is still on appeal to the Indiana Supreme Court.

Robert J. Byrne, M.D.

Dr. Byrne, 77, a retired Bicknell family practitioner, died April 22 at Good Samaritan Hospital in Vincennes.

He was a 1940 graduate of the St. Louis University School of Medicine and served as an Army Medical Corps captain during World War II.

Dr. Byrne, who practiced in Bicknell from 1946 to 1989, was a past president of the Knox County Medical Association. He was named Man of the Year during Bicknell's Labor Day celebration in 1977 in recognition of his dedication to his job and service to the community.

William J. Gerding, M.D.

Dr. Gerding, 77, a retired Fort Wayne family physician, died May 2 at St. Joseph Medical Center.

He was a 1942 graduate of the Indiana University School of Medicine and a Navy Medical Corps veteran of World War II.

Dr. Gerding was a founding member of the American Academy

of Family Physicians.

Francis P. Jones, M.D.

Dr. Jones, 81, a retired Indianapolis anesthesiologist, died June 9.

He was a 1935 graduate of the Indiana University School of Medicine and a colonel in the Army Medical Corps in World War II.

Dr. Jones was on the staff at St. Francis Hospital in Beech Grove from 1946 to 1984, when he retired. He was a charter fellow of the American Academy of Family Physicians and the College of Anesthesiologists. He was a lifetime member of the 50-Year Club of American Medicine.

Satish C. Julius, M.D.

Dr. Julius, 51, an Evansville ophthalmologist, died May 4.

He was a 1968 graduate of Christian Medical College, Punjab University, India.

Dr. Julius was a member of the American Academy of Ophthalmology, the International Society of Ocular Surgeons, the Royal Society of Medicine and the Tri-State Association of Physicians of India.

John T. Kemp, M.D.

Dr. Kemp, 84, a retired Michigan City family practitioner and surgeon, died May 22 at the Michigan City Health Care Center.

He was a 1935 graduate of the Northwestern University Medical School and a Medical Corps veteran of World War II.

Dr. Kemp had been a member of the American Society of Anesthesiologists and chief of staff at St. Anthony Hospital.

Joseph L. Larmore, M.D.

Dr. Larmore, 80, a retired Anderson ophthalmologist, died April 22, at his residence in Carmel.

He was a 1937 graduate of the

Indiana University School of Medicine and served as an Army surgeon during World War II.

Dr. Larmore, an Anderson physician for 40 years, was a member of the American College of Surgeons and the American Academy of Otolaryngology.

Howard E. Rendel, M.D.

Dr. Rendel, 74, a retired Peru family practitioner, died May 20 at Dukes Memorial Hospital in Peru.

He was a 1942 graduate of the

Indiana University School of Medicine and an Army Medical Corps veteran of World War II.

Dr. Rendel practiced medicine in Peru from 1942 until his retirement in 1988.

Warren C. Roberts, M.D.

Dr. Roberts, 73, former medical director of Western Electric, died July 13 at his home in Indianapolis.

He was a 1943 graduate of New York University School of Medicine and an Army veteran of

World War II.

Dr. Roberts was medical director of Western Electric's facility in Buffalo, N.Y., before coming to the company's Indianapolis plant. He was employee physician and department head for 17 years and retired in 1986. He was a past president of the Indianapolis chapter of the American Lung Association and a former board member of the Indianapolis chapter of the American Heart Association. □

Auto Buyers Network

The #1 priority at Auto Buyers Network is to provide you with an easy, timely, and affordable way to purchase your next new or used car, truck or van. Tell us the make and model vehicle that you prefer and **we** do the legwork. No more disputing with salesmen, wondering and worrying if you're getting a "good deal." We can even arrange leasing or financing utilizing the best rates available from several participating lenders.

▲ Personalized Service Statewide ▲

Auto Buyers Network

Bill Prewitt, ISMA Consultant

40 West 40th Street, Indianapolis, IN 46208

317/ 921-1537 or 800/736-0172

Dr. Marlin L. Troyer of South Bend is the new president of the Indiana Orthopaedic Society. Other officers are: Dr. Claude C. Reeck, Indianapolis, president-elect; Dr. Robert L. Forste, Columbus, past president; Dr. Clyde B. Kernek, Indianapolis, secretary-treasurer; Dr. Alan J. Habansky, Muncie, member-at-large; and Dr. J. Edward Waggoner, Lafayette, membership committee chairman.

Dr. Randolph W. Lievertz of Indianapolis presented a lecture on "Alternative Therapies for Postmenopausal Osteoporosis" at a regional conference on "Therapeutic Alternatives in the Prevention of Postmenopausal Osteoporosis" sponsored by West Penn Hospital in Pittsburgh. He spoke on "Pathogenesis and Prevention of Postmenopausal Osteoporosis" at Tri County Community Hospital in LaGrange, Ky.

Dr. Mark A. Cepela, an Indianapolis ophthalmic plastic and reconstructive surgeon, received the Merrill Reyh Award at the annual fall meeting of the American Society of Ophthalmic Plastic and Reconstructive Surgery; the award was given for his thesis on "Stimulation of Orbital Growth by the Use of Expandable Implants in the Anophthalmic Cat Orbit."

Dr. William R. Nunery, an Indianapolis ophthalmic plastic and reconstructive surgeon, lectured in Geneva, Switzerland, at the second International Symposium on Ocular Trauma; his topic was reconstruction surgery of the eyelids, lacrimal apparatus and orbit following trauma.

Dr. Scott A. Shapiro, a neurosurgeon at the Indiana University School of Medicine, presented three papers at the American Association of Neurological Surgeons annual Cushing Meeting

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

May 1992

Aeschliman, William J., Fort Wayne
Alexander, Panos C., Kokomo
Brown, Timothy N., Crawfordsville
Condit, Jonathan D., Eaton
Fallon, John H., Fort Wayne
Good, Richard L., Munster
Huber, Richard G., Bedford
Irwin, Gerald P., Alexandria
Mouser, Robert W., Indianapolis
Myron, Stephen R., Portland
Purcell, Richard J., Griffith
Reidy, James E., Mishawaka
Richards, Mark G., Carmel
Scherschel, Kim P., Bedford
Snow, Daniel J., Scottsburg
Solotkin, David, Indianapolis
South, Terry A., Evansville
Willage, Mark B., Huntingburg

June 1992

Amorini, Michael F., Fort Wayne
Barrett, Shari L., Evansville

Blumenthal, Kenneth W., Portage
Cantwell, Michael L., Vincennes
Chu, Johnson C., Walton
Cleary, Robert E., Indianapolis
Connerly, Patrick W., New Haven
Doles, Ted S., Muncie
Dolezal, Bernard J., South Bend
Duque, Fausto, Jeffersonville
Elliott, Edward F., Carmel
Ferrara, Thomas A., Indianapolis
Haerr, Robert W., Terre Haute
Haste, John L., Argos
Hussey, Lawrence K., South Bend
Kauffman, Gerald G., Elkhart
Koenig, Robert L., Valparaiso
Lee, Thomas M., Hartford City
Lim, Young S., Evansville
Rustagi, Prevesh K., Fort Wayne
Schwartz, Alan L., Indianapolis
Sentany, Marki S., Indianapolis
Van Hove, Eugene D., Carmel
Woodruff, Richard N., Richmond
Wrenn, Robert E., Bloomington
Yocum, William S., Merrillville
Zeph, Richard D., Carmel

in San Francisco; his topics were "Management of Unilateral Locked Facet of the Cervical Spine," "Cauda Equina Syndrome Secondary to a Lumbar Disc Herniation" and "Neurotransmitter Alterations in Spinal Cord Injury." The paper on cauda equina syndrome won an award in the poster category.

Dr. Stephen W. Perkins, an Indianapolis facial plastic and reconstructive surgeon, was course director of the American Academy of Facial Plastic and Reconstructive Surgery seminar titled "Rejuvenation of the Face -

1992," held in May in Indianapolis. He spoke on "Extended Lower Blepharoplasty with Treatment of Malar Pads," "Chemical Peeling of the Lower Eyelids," "Nasal Vascular Collapse," "Submental Tuck-Up: Submentoplasty," "Dermabrasion of the Aging Face," "Expected Complications and Management in Chemical Face Peeling," "Post-operative Care for Chemical Peeling" and "Accreditation/Certification of an Office Surgical Suite."

Dr. Bill L. Martz, professor emeritus at the Indiana University School of Medicine, was elected to

a three-year term on the board of directors of the Visiting Nurse Association in Indianapolis.

Dr. Robert D. Glassman, a cardiologist with Midwest Heart Associates in Danville and Indianapolis, has earned board certification in critical care medicine.

Activities and accomplishments of physicians at the Indiana Hand Center in Indianapolis include the following: **Dr. Hill**

Hastings II was a co-organizer of the first AO Hand Course held in Buenos Aires, Argentina; he gave seven lectures, six of which were delivered in Castellano. He also was a faculty member for the

Endoscopic Carpal Tunnel Release Workshop in Denver and lab coordinator for the AO/ASIF Internal Fixation Hand Course in San Diego. **Dr. James J. Creighton Jr.** spoke on "Cumulative Trauma Disorders: Causes and

Compensability" at a meeting of the Indiana Self-Asurers Association.

Dr. James W. Strickland hosted the eighth annual Indianapolis-Louisville-Cincinnati Hand Conference at the Indiana Hand Center. He also delivered the first Stromberg Memorial Lectureship for the Chicago Hand Society; his topic was "Hand Surgery: Then and Now, 1969-1992." He was a faculty member and **Dr. William B. Kleinman** was a

speaker at the International Congress of Hand Surgery in Paris, France. **Dr. Thomas J. Fischer** was assistant lab coordinator for the AO/ASIF Internal Fixation Hand Course in San Diego. **Dr. Alexander D. Mih** lectured at St. Mary's Medical Center in Evansville for IU Visiting Professor Grand Rounds.

Dr. Vidyasagar S. Tumuluri, an Indianapolis hand surgeon, collected more than \$11,000 in pledges for WalkAmerica '92 for

the March of Dimes; he was named the top walker for the second year.

Several physicians were honored during the annual banquet of the Indiana Academy of Family Physicians at French Lick Springs Resort. **Dr. Jack W. Higgins** of Kokomo was named Family Physician of the Year in recognition of outstanding contributions in patient care and community activi-

ties. **Dr. Edward L. Langston**, director of the family practice residency program at Community Hospital in Indianapolis, received the Lester D. Bibler Award; the award recognizes long-term dedication and effective leadership toward furthering the development of family medicine. **Dr. Elmer S. Zweig** of Fort Wayne received the Distinguished Public Service Award for his work in the

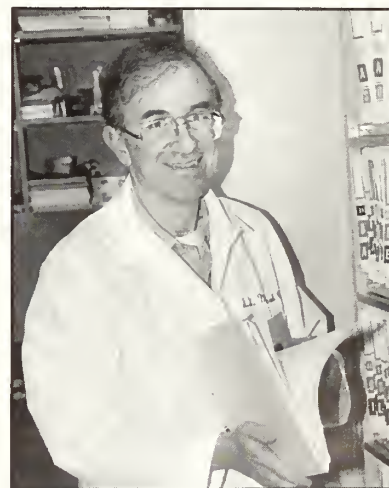
IU physician receives cancer research prize

Lawrence H. Einhorn, M.D., an oncologist at the Indiana University Medical Center in Indianapolis, was one of three winners of the annual General Motors Cancer Research Foundation Prizes. He received the Charles F. Kettering Prize for contributions to cancer treatment.

Dr. Einhorn was honored for pioneering the successful use of the drug cisplatin in cancer therapy. His work was pivotal in conquering testicular cancer, now the most curable of all cancers but once uniformly fatal. It is the most common cancer among males between the ages of 15 and 35. His approach with testicular cancer has been adopted worldwide for treating many other tumors.

He is now involved in several clinical trials using experimental approaches to help testicular cancer patients not cured by other means. He has begun tests with a distant cousin of vitamin A, all-trans-retinoic acid, to coax patients' highly malignant and drug-resistant cancer cells to mature into normal adult cells. He is testing very high-dose chemotherapy with bone marrow transplants and also is planning clinical trials with taxol, a drug made from the bark of the yew tree.

Dr. Einhorn received a \$100,000 award, as well as \$30,000 to hold a scientific workshop or conference to share his work with other research scientists. The award was presented during a ceremony at the National Academy of Sciences in Washington, D.C., followed by a formal dinner at the Department of State. ■



Dr. Einhorn

■people

treatment of alcoholism and drug dependence; he helped develop the alcoholic treatment center at Parkview Memorial Hospital and has been president of the Fort Wayne Committee on Alcoholism.

Dr. Harry Siderys, a cardiovascular and thoracic surgeon at Methodist Hospital in Indianapolis, has retired; he performed the first coronary bypass surgery and the first carotid surgery in Indiana.

Dr. Ronald G. Blankenbaker of Indianapolis was re-elected to another three-year term as a trustee of the Catholic Health Association of the United States.

The Northern Indiana Education Foundation has honored two Michigan City doctors. **Dr. Vidya S. Kora**, an internist, received the 1991 Most Educated Physician award for having attended the most monthly continuing education lectures sponsored by the foundation. **Dr. William H. Rosevear**, an otolaryngologist, received the 1991 Best Read Doctor award for his frequent use of the foundation's medical library.

Dr. Stacy Lankford, an Elkhart urologist, was appointed to a four-year term on the Indiana Medical Licensing Board.

Dr. Alvin Korba, an Evansville radiation oncologist, received an international scientific award for his work in the field of high-dose radiation treatments for cancer patients. The award was presented by Isotopen-laboratorium, Dr. Kurt Sauerwein, GMBH, the company that manufactures the Gamma Med machine used in the radiation treatments.

Dr. William F. Buechler celebrated 40 years as an Elwood family practitioner during an open house in May.

Dr. Lindley H. Wagner, a Lafayette internist, was inducted as a fellow of the American Col-

lege of Physicians.

Dr. James K. Malone, associate director of the Joslin Diabetes Clinic at Methodist Hospital in Indianapolis, was elected president of the Indiana Affiliate of the American Diabetes Association.

Dr. Helen J. Kinsey of Columbus was certified by the American Board of Obstetrics and Gynecology.

Dr. Ilya Schwartzman of Columbus has been certified by the American Board of Family Prac-

First woman to receive Beering Award from IU

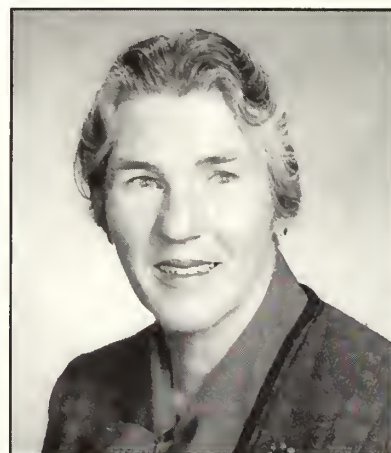
Janet D. Rowley, M.D., a professor in the Department of Molecular Genetics and Cell Biology at the University of Chicago, will receive this year's Steven C. Beering Award from the Indiana University School of Medicine.

The Beering lecture and award ceremony will be held at 8:30 a.m. Wednesday, Oct. 28, at the University Place Conference Center in Indianapolis. The title of her lecture will be "Chromosome Translocations: Dangerous Liaison."

Dr. Rowley, the first woman to receive the Beering Award since it was initiated in 1984, will speak to freshman and sophomore medical students on "The Role of Chromosome Abnormalities in Human Leukemia and Lymphoma" at 11 a.m. Oct. 27 in Emerson Auditorium.

A graduate of the University of Chicago School of Medicine, Dr. Rowley has been at the University of Chicago since 1962. She was awarded the Blum-Riese Distinguished Service Professorship by the university in 1984 and is the president-elect of the American Society of Human Genetics. She has received numerous awards for her work, including the Clowes Award from the American Association for Cancer Research and the Mott Prize from the General Motor Cancer Research Foundation.

Dr. Rowley has been involved in the most important developments in tumor cytogenetics in the last two decades. She was one of the first to apply the new chromosome banding techniques to human leukemia. In 1973, she discovered the first consistent chromosome rearrangement that was identified in any human or animal malignant or non-malignant disease, namely the translocation involving chromosomes 9 and 22 in chronic myelogenous leukemia. She also discovered a number of consistent translocations and other rearrangements in acute myelogenous leukemia and in malignant lymphoma. □



Dr. Rowley

tice.

Dr. R. Lee Walton, a Marion pediatrician since 1960, has retired. □

New ISMA members

Harish P. Ardesbna, M.D., Bluffton, pulmonary diseases.

Jeffrey M. Blake, M.D., Anderson, obstetrics and gynecology.

James E. Bollier, M.D., Indianapolis, pediatrics.

James M. Brackman, M.D., Fort Wayne, anesthesiology.

Beth L. Buchanan, M.D., Fortville, family practice.

Jeff Cahoon, M.D., Lafayette, diagnostic radiology.

Taekae Chong, M.D., Indianapolis, nephrology.

Daniel J. Cumiskey, M.D., Fort Wayne, orthopaedic surgery.

Jerry E. Douglas, M.D., Lafayette, family practice.

Robert A. Dykstra, M.D., Fort Wayne, anesthesiology.

Rafik S. Farag, M.D., Peru, general surgery.

Lloyd W. France III, M.D., Fort Wayne, anesthesiology.

Gabra S. Gachaw, M.D., Plainfield, psychiatry.

Andrew P. Garlisi, M.D., Michigan City, emergency medicine.

Mark E. Gentry, M.D., Danville, obstetrics and gynecology.

Arve W. Gillette, M.D., Indianapolis, radiation oncology.

John Greenman, M.D., Bluffton, occupational medicine.

Bassam N. Helou, M.D., Indianapolis, internal medicine.

Chester A. Jastremski, M.D., Bloomington, family practice.

Ranga R. Kota, M.D., Bluffton, gastroenterology.

Jean L. Kraft, M.D., Indianapolis, diagnostic radiology.

Paul E. Later, M.D., Fort Wayne, neurology.

Evan L. Lehman, M.D., Martinsville, obstetrics and gynecology.

Dennis G. Lockrey, M.D., Lafayette, family practice.

Bernardo S. Lucena, M.D., Crown Point, internal medicine.

Charles D. Magill, M.D., LaPorte, orthopaedic surgery.

Kirk E. Masten, D.O., Fort Wayne, anesthesiology.

Mikal M. Moga, D.O., Fort Wayne, family practice.

Gregory W. Moore, M.D., Bloomington, emergency medicine.

Woodrow A. Myers Jr., M.D., Indianapolis, internal medicine.

Mark J. Ormson, M.D., South Bend, diagnostic radiology.

Promila D. Paul, M.D., Munster, ophthalmology.

Neil M. Richman, M.D., Fort Wayne, orthopaedic surgery.

Basil M. Salaymeh, M.D., Greencastle, vascular surgery.

Paresh Shah, M.D., Frankton, internal medicine.

Datchen F. Tai, M.D., Bloomington, hematology.

Smari Thordarson, M.D., LaPorte, diagnostic radiology.

Beatrice C. Travis, M.D., Bloomington, anesthesiology.

Gary H. Wheeland, M.D., LaPorte, family practice.

William E. Wolf III, M.D., LaPorte, anesthesiology.

Teri L. Wright, M.D., Bluffton, pediatrics.

Jip Yoon, M.D., Warsaw, internal medicine.

Residents

Lois P. Buschbacher, M.D., Indianapolis, physical medicine and rehabilitation.

Timothy A. Goedde, M.D., Indianapolis, general surgery.

Kimberly A. Harper, M.D., Carmel, obstetrics and gynecology.

Frank R. Kolisek, M.D., In-

dianapolis, orthopaedic surgery.

Jeffrey A. Mathison, M.D., Anderson, family practice.

Trent M. Miller, M.D., Indianapolis, anesthesiology.

Jeffrey R. Mossler, M.D., Indianapolis, cardiovascular diseases.

Jeffrey A. Ollo, M.D., Batesville, orthopaedic surgery.

Bryan K. Perkins, M.D., Indianapolis, obstetrics and gynecology.

Catherine C. Rupp, M.D., Indianapolis, internal medicine.

Antonio Santin-Hodges, M.D., Indianapolis, plastic surgery.

Blaine Y. Takesue, M.D., Indianapolis, internal medicine.

Chanh M. Tu, M.D., Indianapolis, ophthalmology.

G. Alan Von Stein, M.D., Indianapolis, obstetrics and gynecology.

Martin B. Wehlage, M.D., Indianapolis, anesthesiology.

Lisa Wiersema, M.D., Indianapolis, anatomic/clinical pathology. □

Correction

Briah Zeh is the executive director at Clinton County Hospital in Frankfort, and Todd Stallings is the administrator at Jennings Community Hospital in North Vernon. Stallings was misidentified as the Clinton County Hospital executive director in the story titled "Recruiting doctors: Big job for small towns" in the July issue of *INDIANA MEDICINE*. Zeh, not Stallings, should have been mentioned in reference to Clinton County Hospital's successful use of a recruiting video. Other comments in the story attributed to Stallings also should have been attributed to Zeh. □

■ classifieds

STUDENT HEALTH PHYSICIAN for outpatient medical care of adolescents and adults. Primary care physician with board certification preferred. Licensed or eligible for Indiana. No weekend or night hours. Excellent benefit package. Send curriculum vitae to Robert Hongen, M.D., Medical Director, Indiana University Health Center, 600 N. Jordan Ave., Bloomington, IN 47405. Indiana University is an Affirmative Action/Equal Opportunity Employer.

SUBURBAN COLUMBUS, OHIO - Group of four radiologists seeks a fifth: films, CT, MRI, nuclear medicine, ultrasound. 60,000 cases/year; 56 employees. Radiology department soon to triple space. Compensation: \$220,000+ and bonus. Near Columbus with its major university, culture, shopping. Call Walter Smith, 1-800-221-4762.

CHIEF MEDICAL OFFICER for Department of Veterans Affairs, Adam Benjamin Jr. Outpatient Clinic in Crown Point, Ind. Immediate opening for qualified physician to manage satellite clinic of a university-affiliated, Chicago-based tertiary care VA medical center. Opportunity offers Northwestern University Medical School faculty appointment to qualified individual, regular hours, a state-of-the-art facility, on-site specialty services and a competitive salary. Position includes managerial duties, clinical practice and teaching. Research opportunities available. Qualifications include board eligibility/certification in a recognized medical specialty and U.S. citizenship or permanent alien status. Internist with previous management experience preferred. We are an Affirmative Action/Equal Opportunity Employer. Qualified women and minority candidates are encouraged to apply. Position is subject to drug screening. Send curriculum vitae to Raymond Zeiss, M.D., Acting Chief of Staff (11), VA Lakeside Medical Center, 333 E. Huron St.,

Chicago, IL 60611.

GENERAL INTERNISTS, full- or part-time, needed for the Department of Veterans Affairs Lakeside Medical Center in Chicago, Ill., and its satellite facility, the Adam Benjamin Jr. Outpatient Clinic in Crown Point, Ind. Northwestern University Medical School faculty appointments are available to qualified persons. We offer regular hours, no in-house night call, challenging patients, on-site specialty services, modern facilities, well-trained colleagues and a competitive salary. Qualifications include board eligibility/certification in internal medicine and U.S. citizenship or permanent alien status. We are an Affirmative Action/Equal Opportunity Employer. Qualified women and minority candidates are encouraged to apply. Successful applicants may be asked to undergo drug screening as a condition of employment. Send curriculum vitae to Ken Khuans, M.D., Acting ACOS for Ambulatory Care (11C), VA Lakeside Medical Center, 333 E. Huron St., Chicago, IL 60611.

EMERGENCY CARE PHYSICIANS - Expanding emergency medicine group seeking career-minded physicians for multiple Indiana locations. Twenty-year history without a lost contract. Hourly compensation based on training, experience and qualifications. Excellent benefits include 401(k) pension plan; malpractice, health, life and disability insurance; CME allowance; and ACEP, ISMA and hospital dues. Will consider all physicians with emergency medicine experience and interest. Contact Jim Gardner, M.D., Director, Corporate Development, Emergency Care Physicians, 640 S. Walker St., Suite A, Bloomington, IN 47403, (812) 333-2731.

IMMEDIATE CARE PHYSICIANS - Expanding immediate care group seeks career-minded primary physicians for multiple Indianapolis

locations. Corporation is physician-owned and operated with 11 years of experience in Indianapolis metropolitan area. Compensation based on training, experience and qualifications. Excellent benefits include 401(k) pension plan; malpractice, health, life and disability insurance; CME allowance; and ACEP, ISMA and county dues. Will consider all primary medical disciplines with interest in outpatient medicine. Full-time opportunities only. Contact Jim Gardner, M.D., Director, Corporate Development, Emergency Care Physicians, 640 S. Walker St., Suite A, Bloomington, IN 47403, (812) 333-2731.

OCCUPATIONAL HEALTH PHYSICIAN - Community Hospitals Indianapolis. Join the occupational health medical team of Company Care, a division of Community Hospitals Indianapolis. Position focuses three-quarters of the physician's time (30 hours) providing on-site services to our 5,000 employees; the remaining time providing clinical occupational medicine services in our ambulatory care centers. Position immediately available. Three years post-residency experience in either occupational medicine, emergency medicine, internal medicine or family practice required, with some experience in practice of occupational medicine. Salary commensurate with experience. Forward curriculum vitae to Steven R. Smith, M.D., Director, Occupational Medicine, Community Hospitals Indianapolis, 1709 N. Post Road, Indianapolis, IN 46219-1969, (317) 898-4151.

OHIO-WISCONSIN-MICHIGAN-MISSOURI - Attractive opportunities in metropolitan and scenic recreational areas. Locations near pristine lakes, white water rivers and national forests. Others in college communities offering professional and Big 10 college sports, fine arts and a broad spectrum of nationally renowned CME programs. Positions available: allergy, dermatology, neurosurgery, occupational

medicine, oncology, orthopaedics, otolaryngology, psychiatry, rheumatology and urology. To discuss your practice preferences and these opportunities, please call our toll-free number, 1-800-243-4353, or send your CV to STRELCHECK & ASSOCIATES, INC., 10624 N. Port Washington Road, Mequon, WI 53092.

INTERNAL MEDICINE, FAMILY PRACTICE, URGENT CARE, OB/GYN AND ACADEMICS: Positions in large metropolitan cities, urban and rural communities with a concentration in the Great Lakes area and Plains states. Whether you prefer a cosmopolitan lifestyle, a city surrounded by nature and the beauty of the four seasons, the peaceful rolling farm country or perhaps life in historic villages - there is something for everyone. To discuss your practice preferences and these opportunities, please call our toll-free number, 1-800-243-4353, or send your CV to STRELCHECK & ASSOCIATES, INC., 10624 N. Port Washington Road, Mequon, WI 53092.

FOR SALE: Medical equipment. Cavitron, extra capsular cataract removal system complete with manuals. Cryostats Ophthalmology, one nitrous oxide, one carbon dioxide. OR lights, Castle Double Reflectors, halogen. Ohio anesthesia machines, one aerrane with shelf, one fluothane-forane with ventilator and shelf, one ethrane-forane-fluothane with ventilator and shelf. Picker Echo View Ultrasound Systems, manuals. Picker C Arm, excellent. G.E. portable x-ray. Microscopes. Hewlett-Packard heart monitors, defib and printout. Bircher Hypercaters, elec. surg. X-ray view boxes. Microhemocrits. Infant scales. Call or write Bernard Medical Resources, 1555 Dixie Highway, Covington, KY 41011, 1-800-892-3716 or (606) 581-5205.

INTERNAL MEDICINE/ORTHOPAEDIC SURGEON - Outstanding practice

opportunity in one of the most attractive locations in the Midwest - Goshen, Ind. Located in north central Indiana, Goshen is bordered by hundreds of sparkling lakes, numerous wooded parks and unspoiled rolling countryside. Its proximity to South Bend, home of the University of Notre Dame, provides a wide spectrum of spectator sports, quality concerts, theater and fine dining. Goshen College embodies the community's commitment to quality education. A strong economy (Goshen's manufacturing employment growth was ranked 16th in the nation by American Demographics) helps ensure a quality lifestyle. For more information, contact Rick Addis, Goshen General Hospital, P.O. Box 139, Goshen, IN 46526; hospital, 1-800-258-4321, or home, (219) 533-8311.

WANTED - FAMILY PRACTICE PHYSICIAN. We are looking for a hard-working, patient-oriented, board-certified or board eligible family practice physician. The ideal candidate will have the opportunity to practice in a non-hostile, friendly environment where excellence in patient care is the standard, not the exception. Our unique family practice opportunity includes: no call, no weekend coverage, pleasant working environment, competitive salary and complete benefit package including malpractice insurance, CME, three weeks paid vacation, paid holidays, paid sick leave, paid health, life and disability insurance, participation in a lucrative defined benefit pension plan, stock ownership opportunity after one year. If interested in learning more about this unique opportunity, please send or fax, (219) 422-1627, a cover letter and a copy of your curriculum vitae to John J. Waszak, Administrator, Arata Medical Group, 3301 Lake Ave., Fort Wayne, IN 46805.

PHYSICIAN PRACTICE OPPORTUNITIES - Statewide/nationwide/worldwide. All specialties, group/solo,

varied income arrangements. Contact Larson & Trent Associates, Box 1, Sumner, IL 62466-0001. Telephone: (618) 936-2662, 936-2970 or (800) 352-6226.

PSYCHIATRIST - Full- and part-time openings now available at Central State Hospital in Indianapolis. Competitive salary, state employment benefits, flexible hours. Challenging assignments in direct patient care. Call medical director, James Donahue, M.D., (317) 639-3636.

RADIOLOGY - Seven-person group is seeking an eighth radiologist with special interest in cross-sectional imaging. The Department of Radiology is expanding, is well-staffed and has all new and modern equipment. The initial salary is competitive, with a guaranteed bonus. The all-inclusive benefits are generous, with partnership potential. The excellent practice opportunity offers suburban living at its best and is located 45 minutes from downtown Chicago. For further information, please contact Peter E. Doris, M.D., Chairman, or Antigoni Kencos, M.D., Vice Chairman, Department of Radiology, St. Anthony Medical Center, Crown Point, IN 46307, (219) 757-6320.

FAMILY PRACTICE opportunities available in Fort Wayne, Ind. Practice setting extremely flexible. Solo or group. Salary guarantee, relocation and other expenses paid. An opportunity to practice medicine and leave administrative and billing headaches to someone else. For complete details, contact our physician recruiting officer at (219) 489-2772, ext. 415.

URGENT CARE - FT or PT opportunities available in busy, well established Cedar Rapids urgent care center. Occupational medicine, including pre-employment evaluations and work-related injury treatment, is also part of the practice. X-ray, laboratory and physical therapy services available within

■ classifieds

clinic. Cedar Rapids, population 110,000, is located in eastern Iowa and is 30 minutes from the University of Iowa. Excellent compensation and scheduled hours. Mail CV or call Bob Waste, Mercy Care Management, P.O. Box 786, Cedar Rapids, IA, 52406, (319) 398-6460.

EMERGENCY MEDICINE - Our high-quality, low-key emergency medicine group is looking for a BC/BE or well-experienced emergency physician to join our practice at a 29,000-volume E.D. We are a fee-for-service group with good income and benefits. Full salary attained in only one year. Lafayette is a safe and pleasant college town, allowing for a high quality of living. Contact Lance Seagren or John Woods at (317) 447-4517, 1308 Lockwood Dr., Lafayette, IN 47905.

DOOR COUNTY, WISCONSIN - BC/BE internist. Modern, 89-bed community hospital with new outpatient services addition. Competitive guaranteed salary. Incentive package. Malpractice insurance. Attractive benefits. Exceptional four seasons recreation along Lake Michigan shores. Proximity to Milwaukee/Chicago. Top-rated schools. Quality community life. Send CV to Priscilla Khoury, Physician Recruitment Coordinator, 330 S. 16th Place, Sturgeon Bay, WI 54235.

DOOR COUNTY, WISCONSIN - Emergency medicine. BC/BE family practice, internal medicine,

pediatrics or emergency medicine. General emergency medicine experience required. ACLS/ATLS required, PALS preferred. Full-time position with 8-10 24-hour shifts monthly with flexibility. Competitive salary and benefits package. Modern 89-bed hospital with a new emergency department and outpatient services addition. Approximately 10,000 visits per year. Exceptional four seasons recreation along Lake Michigan shores. Proximity to Milwaukee/Chicago. Top-rated schools. Quality community life. Send CV to Priscilla Khoury, Physician Recruitment Coordinator, 330 S. 16th Place, Sturgeon Bay, WI 54235.

FAMILY PRACTITIONERS/INTERNISTS - MetroHealth, an affiliate of Methodist Hospital of Indiana, Inc., is seeking board-certified/eligible family practitioners and internists. Share the advantages of joining an established prepaid multi-specialty physician group offering an ideal blend of practice and lifestyle, paid professional liability and competitive compensation and fringe benefit packages. Our practice is located in Indianapolis, a thriving Midwest community offering a number of cultural, educational and recreational activities. For confidential consideration, submit curriculum vitae to MetroHealth Physician Recruitment, P.O. Box 1367, Indianapolis, IN 46206.

MULTIPLE AND VARIED physician practice opportunities currently

exist both within and outside Indiana. Call Patti Quiring at work, (317) 841-7575, or at home, (317) 823-4746. Patti is a physician recruiter for Quiring Associates, an executive search firm headquartered in Indianapolis.

GENERAL INTERNIST - BC/BE. To join a busy five-man practice with special interest in hospital intensive care, plus consultative and primary care practice in the Indianapolis area. Will offer partnership. Reply to Box 19616, Indianapolis, IN 46219.

EMERGENCY MEDICINE - Terre Haute, Ind. Local multi-hospital group seeking full-time career-oriented emergency physician for position in small- and medium-volume community hospitals. Flexible scheduling, very competitive compensation package, partnerships available. Send CV or contact William R. Grannen, Priority Health Care, P.C., 7179 Lamplite Ct., Cincinnati, OH 45244, (513) 231-0922.

CENTRAL INDIANA - Physician-owned emergency group accepting applications for full-time, career-oriented emergency physicians. Flexible work schedules and excellent benefit package. Part-time and directorship positions also available. Send CV or contact Midwest Medical Management, Inc., 3645 S. East St., Indianapolis, IN 46227-1240, (317) 783-7474. □

OFFICERS

President — C. Dyke Egnatz, Schererville
 Pres.-elect — William H. Beeson, Indianapolis
 Immediate Past Pres — Michael O. Mellinger, LaGrange
 Executive Director — Richard R. King, Indianapolis
 Treasurer — John A. Bizal, Evansville
 Asst. Treasurer — Timothy Brown, Crawfordsville
 Speaker — William C. Van Ness II, Summitville
 Vice Speaker — William E. Cooper, Columbus

EXECUTIVE COMMITTEE

*C. Dyke Egnatz, Schererville
 William H. Beeson, Indianapolis
 Michael O. Mellinger, LaGrange
 Peter Winters, Indianapolis
 John A. Bizal, Evansville
 Timothy Brown, Crawfordsville
 Alfred Cox, South Bend
 Jerome Melchior, Vincennes
 William C. Van Ness II, Summitville
 William E. Cooper, Columbus

TRUSTEES (Terms end in October)

District

- 1 — Bruce Romick, Evansville (1992)
- 2 — Jerome E. Melchior, Vincennes (1993)
- 3 — Gordon L. Gutmann, Jeffersonville (1994)
- 4 — Arthur C. Jay, Lawrenceburg (1992)
- 5 — Fred E. Haggerty, Greencastle (1993)
- 6 — Ray Haas, Greenfield (1994)
- 7 — Donna J. Meade, Indianapolis (1992)
- 7 — John M. Records, Franklin (1993)
- *7 — Peter L. Winters, Indianapolis (1994)
- 8 — John V. Osborne, Muncie (1993)
- 9 — Stephen Tharp, Frankfort (1994)
- 10 — Nicholas L. Polite, Hammond (1992)
- 11 — Jack W. Higgins, Kokomo (1993)
- 12 — John R. Thomas, Fort Wayne (1994)
- 13 — Alfred C. Cox, South Bend (1992)
- RMS — Clint E. Myers, Indianapolis (1992)
- MSS — Paul Forman, Indianapolis (1992)
- *Chairman

ALTERNATE TRUSTEES (Terms end in October)

District

- 1 — Barney R. Maynard, Evansville (1994)
- 2 — James P. Beck, Washington (1992)
- 3 — John H. Seward, Bedford (1992)
- 4 — Robert L. Forste, Columbus (1994)

- 5 — Roland M. Kohr, Terre Haute (1994)
- 6 — Howard C. Deitsch, Richmond (1992)
- 7 — Ronald G. Blankenbaker, Indianapolis (1994)
- 7 — Bernard J. Emkes, Indianapolis (1992)
- 7 — Charles O. McCormick III, Greenwood (1993)
- 8 — Susan K. Pyle, Union City (1994)
- 9 — Robert E. Darnaby, Rensselaer (1992)
- 10 — Frank M. Sturdevant, Valparaiso (1994)
- 11 — Laurence K. Musselman, Marion (1992)
- 12 — Charles M. Frankhouser, Fort Wayne (1992)
- 13 — Richard J. Houck, Michigan City (1994)
- RMS — Carla Brumbaugh, Indianapolis (1992)
- MSS — Scott Hollingsworth, Indianapolis (1992)

AMA DELEGATES (Terms end Dec. 31)

Marvin E. Priddy, Fort Wayne (1993)
 John D. MacDougall, Beech Grove (1993)
 Herbert Khalouf, Marion (1993)
 John A. Knot, Lafayette (1992)
 Alvin J. Haley, Carmel (1992)
 George T. Lukemeyer, Indianapolis (1992)

AMA ALTERNATE DELEGATES (Terms end Dec. 31)

Michael O. Mellinger, LaGrange (1993)
 George Rawls, Indianapolis (1993)
 Shirley Thompson Khalouf, Marion (1992)
 Max N. Hoffman, Covington (1992)
 Edward L. Langston, Indianapolis (1992)

DISTRICT OFFICERS AND MEETINGS

- 1 — Pres: Gregory Hindahl, Jasper
 Secy: Mariellen Dentino, Evansville
 Annual Meeting: May 20, 1993
- 2 — Pres: Bill Vaughn, Vincennes
 Secy: Mike Kelly, Vincennes
 Annual Meeting: May 13, 1993
- 3 — Pres: John Norton, Corydon
 Secy: Rashidul Islam, New Salisbury
 Annual Meeting: May 19, 1993
- 4 — Pres: Manuel Garcia, Batesville
 Secy: David Welsh, Batesville
 Annual Meeting: May 5, 1993
- 5 — Pres: Paul Houston, Brazil
 Secy: Rahim Farid, Brazil
 Annual Meeting: May 27, 1993
- 6 — Pres: William Toedebusch, Richmond
 Secy: Helen Steussy, New Castle
 Annual Meeting: May 12, 1993
- 7 — Pres: Ronald Stegemoller, Danville

- Secy: Craig Moorman, Franklin
 Annual Meeting: to be announced
- 8 — Pres: Gordon M. Hughes, Muncie
 Secy: Gerard T. Costello, Muncie
 Annual Meeting: June 2, 1993
- 9 — Pres: Thomas A. Mabel, Noblesville
 Secy: Stephen D. Tharp, Frankfort
 Annual Meeting: June 9, 1993
- 10 — Pres: Filemon P. Lopez, Dyer
 Secy: Barron M. Palmer, Hammond
 Annual Meeting: to be announced
- 11 — Pres: Regino Urgena, Marion
 Secy: Frederick C. Poehler, La Fontaine
 Annual Meeting: Sept. 16, 1992
- 12 — Pres: William Aeschliman, Fort Wayne
 Secy: Joseph Mantheiy, Bluffton
 Annual Meeting: Sept. 17, 1992
- 13 — Pres: David Haines, Warsaw
 Secy: John W. Schurz, South Bend
 Annual Meeting: Sept. 9, 1992

COMMISSION CHAIRMEN

Constitution and Bylaws
 Helen E. Czenkusch, Indianapolis
Legislation
 Eugene G. Roach, Anderson
Physician Assistance
 Robert Nelson, South Bend
Medical Services
 Dallas E. Coate, Lebanon
Medical Education
 James E. Carter, Indianapolis
Sports Medicine
 Ronald G. Blankenbaker, Indianapolis

COMMITTEE CHAIRMEN

Medical Malpractice (Ad Hoc)
 George T. Lukemeyer, Indianapolis
Grievance
 Richard B. Schnute, Indianapolis
Indiana Medical Foundation
 Frank B. Ramsey, Indianapolis

CHAIRMEN OF ISMA SPECIALTY SECTIONS

ALLERGY

Paul D. Isenberg, Indianapolis

ANESTHESIOLOGY

Stephen F. Dierdorf, Indianapolis

CUTANEOUS MEDICINE

Peter L. Winters, Indianapolis

DIRECTORS MEDICAL EDUCATION

Glenn Bingle, Indianapolis

EMERGENCY MEDICINE

Thomas C. Madden, Greenwood

FAMILY PRACTICE

John Haste, Argos

INTERNAL MEDICINE

Neil Irick, Indianapolis

MEDICAL DIRECTORS AND STAFF PHYSICIANS OF NURSING FACILITIES

Larry G. Cole, Yorktown

NEUROLOGICAL SURGERY

Marvin R. Bernard, Merrillville

NEUROLOGY

Charles A. Bonsett, Indianapolis

NUCLEAR MEDICINE

Mike Mullinix, Indianapolis

OBSTETRICS & GYNECOLOGY

Philip N. Eskew Jr., Carmel

OPHTHALMOLOGY

D. Dean Cofield, Bloomington

ORTHOPAEDIC SURGERY

James G. Buchholz, Fort Wayne

OTOLARYNGOLOGY, HEAD & NECK SURGERY

William F. Cooper, Columbus

PATHOLOGY & FORENSIC MEDICINE

Joyce Byllesby, Washington

PEDIATRICS

Charlene Graves, Indianapolis

PHYSICAL MEDICINE AND REHABILITATION

Robert Gregori, Indianapolis

PREVENTIVE MEDICINE AND PUBLIC HEALTH

Gary A. Babcoke, Chesterton

PSYCHIATRY

Patricia Sharpley, Indianapolis

RADIOLOGY

Edward C. Wheeler, Carmel

SURGERY

Bud H. McDougal, Indianapolis

UROLOGY

Rodney A. Mannion, LaPorte

ISMA KEY STAFF

Richard R. King, *Executive Director*
 Adele Lash, *Director of Operations/Communications*
 Mike Abrams, *Director of Marketing/Legislation*
 John Wilson, *Director of Administration*
 Ronald Dyer, *General Counsel*
 Susan Grant, *Executive Assistant*
 Richard Ryan, *Field Services (Northern)*
 Bob Sullivan, *Field Services (Central)*
 Janna Kosinski, *Field Services (Southern)*
 Barbara Walker, *Reimbursement Coordinator*
 Tom Martens, *Members Health Insurance*
 Tina Sims, *INDIANA MEDICINE*

You'll love working with our
locum tenens physicians and
allied health care professionals.
WE GUARANTEE IT.

CompHealth has thoroughly credentialed physicians and allied health care providers from more than 40 fields of specialization available to provide locum tenens, or temporary, staffing assistance when and where you need it.

Plus, we have the standards and experience to guarantee your satisfaction each time we place a member of our medical staff in your practice or facility. It's the closest thing you'll find to a risk-free way to cover for absent staff members, "try out" a potential new recruit, or take care of your patients while you search for a new full-time associate.

Call us today to arrange for quality locum tenens coverage, or to discuss your permanent recruiting needs.

CompHealth

COMPREHENSIVE HEALTH CARE STAFFING

1-800-455-5050

Salt Lake City ■ Atlanta ■ Grand Rapids, Mich.

Mark Your Calendars!

Who: ISMA members
What: 143rd annual
convention
When: Oct. 16-18
Where: Westin Hotel in
downtown
Indianapolis

For more information: Call
Jane Breeding, convention
coordinator, (317) 264-1888.

Advertising index

AdminaStar	363
Affiliated Physicians Services	Cover
American Medical Writers Association	422
American Medical Services	453
Arnett Clinic	419
Auto Buyers Network	457
Butterworth Health System	427
Central Pharmaceuticals	365
Child Neurology	453
CompHealth	466
Lilly, Eli & Co.	361
Medical Accounts Group	380, 381
Medical Protective	413
Palisades Pharmaceuticals	422
Physicians' Directory	430
Physicians Insurance Co. of Indiana	Cover
G.D. Searle and Company	Cover
Speedway Mazda	360
University Place	385
U.S. Air Force	369
U.S. Army Reserve	381

In accepting advertising for publication, INDIANA MEDICINE has exercised reasonable precaution to ensure that only reputable, factual advertisements are included. However, we do not have facilities to make comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services, medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertisers only. Neither sanction nor endorsement of such is warranted, stated or implied by the association.

Are you moving?

If so, please send change of address to the Indiana State Medical Association, Membership Department, 322 Canal Walk, Indianapolis, IN 46202-3252, at least six weeks before you move.

Name: _____

Address: _____

City: _____

State: _____ Zip: _____ County: _____

Office phone: _____ Home phone: _____

IMPORTANT - Attach mailing label from your last copy of INDIANA MEDICINE here:

ISMA Health/Dental Insurance

Benefits available to members of the Indiana State Medical Association and their employees through expanded ISMA group sponsored health insurance.

MEDICAL PLAN A

- 365 Days of Inpatient Hospital Care
- 100% payment semi-private or hospital ward room
- 365 Days In-Hospital Medical Care
- 100% reasonable and customary allowances for surgery, maternity, general anesthesia, medical visits, radiation therapy, and other eligible inpatient hospital charges
- \$2,000,000 Major Medical Benefits (\$100 deductible)

MEDICAL PLAN B

- Comprehensive Major Medical protection
- \$250 calendar year deductible, \$500 per family
- Stop-Loss Limit \$5,000 per person, \$10,000 per family
- PCS Card
- Includes cost-containment features
- \$2,000,000 Maximum Benefits

MEDICAL PLAN C

- Comprehensive Major Medical protection
- \$500 calendar year deductible, \$1,000 per family
- Stop-Loss Limit \$5,000 per person, \$10,000 per family
- \$2,000,000 Maximum Benefits

MEDICAL PLAN D

- Economical Comprehensive Major Medical protection
- \$1,000 calendar year deductible, \$2,000 per family
- Stop-Loss Limit \$5,000 per person, \$10,000 per family
- \$2,000,000 Maximum Benefits

MEDICAL PLAN E

- Low cost Comprehensive Major Medical protection
- \$2,000 calendar year deductible, \$6,000 per family
- Stop-Loss Limit \$10,000 per person, \$30,000 per family
- \$2,000,000 Maximum Benefits

BENEFITS FOR ORGAN OR TISSUE TRANSPLANTS

- Included with all medical plans
- Subject to normal plan deductibles and co-insurance
- Covered Transplant Procedures: This benefit covers any of the following human to human organ or tissue transplants: bone marrow; heart; heart/lung; liver; kidney; cornea
- Artery or vein transplants
- Joint replacements
- Heart valve replacements
- Implantable prosthetic lenses in connection with cataracts
- Prosthetic by-pass or replacement vessels
- Maximum Transplant Benefit: \$1,000,000 lifetime maximum per person for all transplant services

DENTAL PLAN

- Reasonable and customary allowances for necessary care and treatment for dental health - \$50 calendar year deductible, \$100 per family
- \$1,500 maximum dental benefit per person in a calendar year paid at 80%, additional major dental paid at 50%
- \$1,000 Orthodontia Benefits paid at 50% of reasonable and customary charges

MEDICAL REIMBURSEMENT PLAN

- Tax deductible to the professional corporation

Your benefit programs have been designed to provide the highest quality coverage and service at the lowest possible cost. A special claim paying unit has been established to handle only the ISMA program. Should you have questions or problems, you may speak directly to your claim processor. We look forward to serving you and encourage your review of the program and services being provided.

For more information regarding these coverages contact:

Tom Martens
Director, Health Insurance Administration
Indiana State Medical Association
322 Canal Walk
Indianapolis, Indiana 46202-3252
(317) 261-2060
800-257-ISMA
FAX (317) 261-2076

Earl W. Williams
Professional Account Representative
11595 N. Meridian St., Suite 802
Carmel, Indiana 46032
(317) 573-6520
800-421-3020
FAX (317) 573-6524

AFFILIATED PHYSICIANS SERVICES, INC.

ISMA Agency

For the many faces of mild hypertension



THE MOST WIDELY USED CALCIUM ANTAGONIST AS MONOTHERAPY FOR MILD HYPERTENSION^{1*}

- Effective 24-hour control²
- Single-agent efficacy
- Well tolerated³
- No adverse effects on total cholesterol, plasma glucose levels, renal function,⁴ or serum electrolytes⁵



For the many faces of mild hypertension

*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

† Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡ Verapamil should be administered cautiously to patients with impaired renal function.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see **Warnings**), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LQT syndrome), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or in patients with symptoms of cardiac failure and in patients with any degree of ventricular dysfunction receiving a beta-blocker. Control milder heart failure with optimum digitalization before Calan SR is used. Verapamil may occasionally produce hypotension. In some cases, hypotension has been reported. Several cases have been demonstrated to be produced by periodic monitoring of liver function in patients on verapamil is prudent. Some patients with small and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LQT syndrome) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular tachycardia after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents.

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil In Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbo KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbo K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:1025-1029.

Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°; 2°; 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomas-tia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

2/13/92 • P92CA7196V

Address medical inquiries to:
G.D. Searle & Co.
Medical & Scientific
Information Department
4901 Searle Parkway
Skokie, IL 60077

SEARLE

Box 5110
Chicago, IL 60680-5110

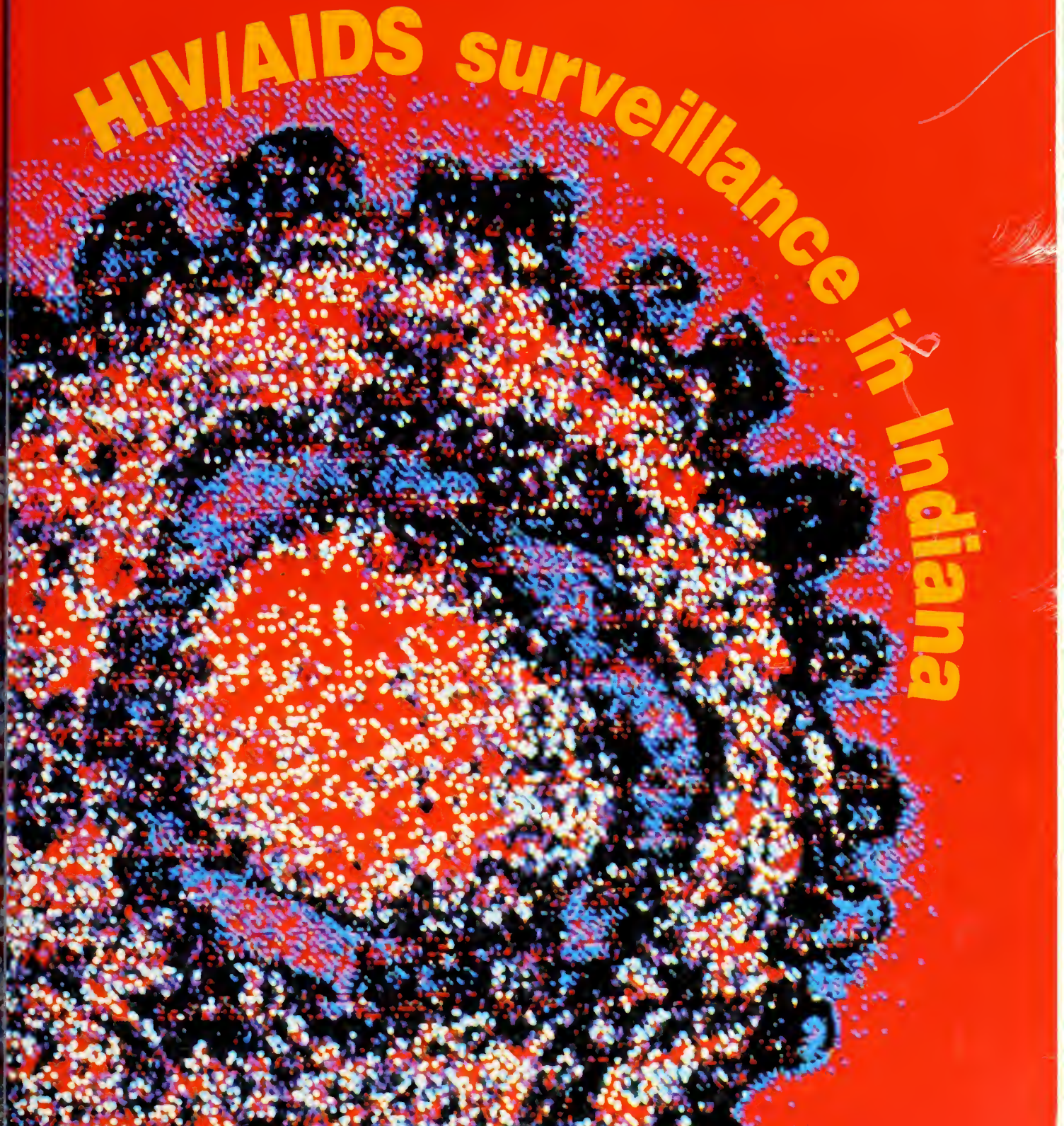
INDIANA MEDICINE

The Journal of the Indiana State Medical Association

November/December 1992

Vol. 85, No. 6

HIV/AIDS surveillance in Indiana



SAFE HARBOR



Smart sailors know where to seek safe harbor. For medical liability protection, Indiana physicians find safe harbor with Physicians Insurance

Company of Indiana, the company formed and owned by the Indiana State Medical Association for that purpose.



PHYSICIANS INSURANCE
COMPANY OF INDIANA



“Together, We Make The Difference”

8425 Woodfield Crossing Blvd., Suite 300 Indianapolis, IN 46240 317/469-4100 800/284-7424

INDIANA MEDICINE

THE FRANCIS A. COUNTWAY
LIBRARY OF MEDICINE
BOSTON, MA
FEB 22 1993

The Journal of the Indiana State Medical Association

November/December 1992

Vol. 85, No. 6

features

IAFP leader dispels myths of family medicine476
John Haste, M.D., president of the Indiana Academy of Family Physicians, offers some suggestions on increasing the number of primary care physicians.

Vagueness of OSHA rules concerns physicians482
Many physicians view the new OSHA regulations on bloodborne pathogens redundant because doctors have had policies in place as part of their infection control plans.

HIV/AIDS surveillance in Indiana486
Although Indiana ranks 23rd in the United States in the total number of AIDS cases reported through June 1992, the AIDS epidemic in Indiana is expanding.

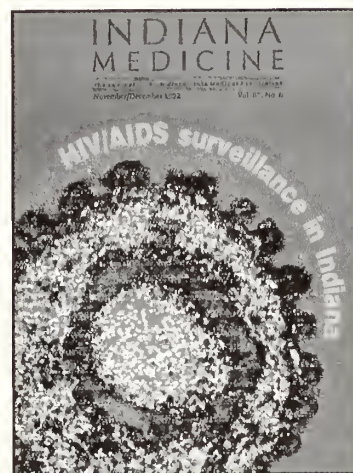
Helping patients receive Social Security benefits490
Physicians should know the considerations Social Security focuses on and how they can help their patients receive maximum benefits.

Doctor prescribes band aid for stress494
When the rock band Not My Kids performs, there's always a doctor in the house. Thomas Kintanar, M.D., enjoys his off-hours as a rock musician.

Index to INDIANA MEDICINE volume 85539

scientific contributions

Intraoperative ultrasound of hepatic tumors496



Cover story on page 486.
Scanning electronmicrograph of intact HIV particle provided by The Stock Market photo agency of New York. Cover design by Diane Alfonso of Indianapolis.

departments

stethoscope470
letter to the editor472
commentary474
scientific commentary500
auxiliary report504
isma leadership505
statement of ownership,
management &
circulation506
from the museum530
cme calendar532
news briefs533
obituaries534
people536
classifieds543

YOCON®

YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

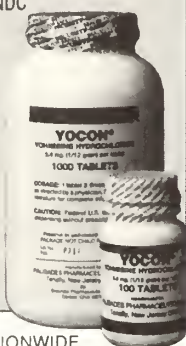
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT PHARMACIES NATIONWIDE

**PALISADES
PHARMACEUTICALS, INC.**

219 County Road
Tenafly, New Jersey 07670
(201) 569-8502
1-800-237-9083

INDIANA MEDICINE

Devoted to the interests of the medical profession and public health in Indiana since 1908.

MANAGING EDITOR

Tina Sims

EDITORIAL ASSISTANT

Toni Settle

BUSINESS MANAGER

Richard R. King

CIRCULATION

Rosanna Iler

EDITORIAL BOARD CHAIRMAN

George T. Lukemeyer, M.D.

EDITORIAL BOARD

Thomas J. Conway, M.D.

Robert C. Ziss, M.D.

(Terms expire Dec. 31, 1992)

James R. Buechler, M.D.

James W. Edmondson, M.D.

Robert L. Forste Jr., M.D.

George C. Manning, M.D.

Bruce F. Waller, M.D.

(Terms expire Dec. 31, 1993)

Panayotis G. Iatridis, M.D.,

(Term expires Dec. 31, 1995)

Franklin Roesner

Paul Forman

(Medical students)

CONSULTING EDITORS

Steven C. Beering, M.D.

Charles A. Bonsett, M.D.

Walter J. Daly, M.D.

Alvin J. Haley, M.D.

Rodney A. Mannion, M.D.

Alan T. Marty, M.D.

EDITOR EMERITUS

Frank B. Ramsey, M.D.

INDIANA MEDICINE (ISSN 0746-8288) is published six times a year (in January, March, May, July, September and November) by the Indiana State Medical Association. Second-class postage paid at Indianapolis, Ind., and additional mailing offices.

Address correspondence relating to editorial material, advertising or subscriptions to: INDIANA MEDICINE, 322 Canal Walk, Indianapolis, IN 46202-3252. Phone (317) 261-2060 or 1-800-257-ISMA.

Annual subscription rates for nonmembers: \$15 domestic, \$17 Canada, \$18 foreign. Medical library rates: \$14 domestic, \$15 Canada, \$16 foreign. Full-time Indiana medical students: \$7. Single copies not available. Subscriptions are renewable annually.

POSTMASTER: Send address changes to INDIANA MEDICINE, Indiana State Medical Association, c/o Membership Department, 322 Canal Walk, Indianapolis, IN 46202-3252.

Views expressed do not reflect the opinions of the editors. No copyright is claimed, unless specifically indicated. Copyright rests solely with authors, who are responsible for statements in their articles. Scientific and editorial contributions are accepted for exclusive publication, subject to editorial requirements. Instructions for authors available on request.

All issues since 1967 are available on microfilm from University Microfilms International, 300 N. Zeeb Road, Ann Arbor, MI 48106. Indexed in *Index Medicus* and *Hospital Literature Index*.

Advertising rates and data available upon request. INDIANA MEDICINE reserves the right to accept or reject advertising.



To Plan The Most Successful Conference Possible, You Really Should Check All Your Options.

The University Place Conference Center & Hotel offers all the options you should expect to make your conference a success. And, probably a few things you'd never expect. So, if you'd like a free information packet on the features listed, call **800-627-2700**. Because once you've checked us out, you won't even consider any other location as an option.



University Place

Conference Center & Hotel

On the Campus of Indiana University • Purdue University
I N D I A N A P O L I S

800-627-2700

(In Indiana 317-274-3196)

Features	<i>University Place</i>
278-room AAA 4-Diamond hotel	✓
Resources of two major universities	✓
338-seat auditorium with sloped seating	✓
Unmatched A/V capabilities	✓
Award-winning restaurants	✓
385-car underground garage	✓
Full-time A/V staff	✓
Turnkey Conference Planning Service	✓
Skywalk to Olympic-class sports facilities	✓
Thirty soundproof meeting rooms	✓
Two tiered meeting rooms	✓
Videoconferencing	✓
Computerized audience response system	✓
Continuous refreshment service	✓

ISMA presents opinions on health policy commission report

Michael Mellinger, M.D., presented the opinions of the Indiana State Medical Association during testimony before the Indiana State Health Policy Commission. The testimony was in response to the commission's draft report on health care reform. Dr. Mellinger, an ISMA past president, is chairman of the ISMA Ad Hoc Task Force on Medical Economics, which discussed the commission report.

Dr. Mellinger said that, although ISMA members appreciated the commission's hard work in the areas of preventive health care and more equitable reimbursement for primary care and preventive services, many concerns remain. The ISMA, said Dr. Mellinger, is opposed to the proposed global budgeting because the plan does not explain what happens to patients who need medical services after funds in the health care budget have been depleted. The lack of physician input in the proposed health delivery system was another concern. For example, the report recommends the establishment of a separate health care licensing corporation whose board of directors would include a majority of consumer representatives. The ISMA does not believe that such a board will be qualified to make decisions about the competence and continuing education of highly trained health care professionals. An additional concern was the area of practice parameters, which physicians would not be required to follow under the proposal; however physicians not following the parameters would not be reimbursed.

The commission was to have delivered its final report to Gov. Evan Bayh Nov. 1. If you have questions, call the ISMA Department of Government Relations, 1-800-257-4762 or (317) 261-2060.

'Escape to the Islands' theme of ISMA legislative reception

Physicians should make plans now to attend the annual ISMA/IMPAC Legislative Reception, set for Wed., Jan. 27, from 6 to 8:30 p.m. at the Westin Hotel in downtown Indianapolis. The reception will give ISMA members a chance to meet state legislators and discuss areas of concern. This year's theme is "Escape to the Islands." For information, call Susan Grant at the ISMA.

CLIA extends registration deadline, drops unannounced inspections

The Health Care Financing Administration (HCFA) has announced a 90-day grace period for completing the Clinical Laboratory Improvement Amendments (CLIA) registration. The new deadline is Dec. 1.

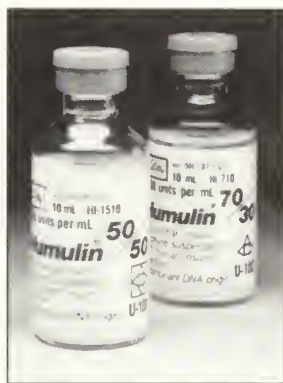
HCFA also said the first routine biannual inspections of physicians' facilities will be educational and will not take place until 1993-1994, unless a complaint is received or a problem is suspected. Laboratories located in physician offices may be surveyed on an announced basis so doctors can schedule time to meet with inspectors. HCFA will continue to pay laboratory claims regardless of CLIA registration until Dec. 1. Those who have not registered by completing HCFA Form 109 should write to HCFA CLIA Program, P.O. Box 26689, Baltimore, MD 21207-0489. □



Because One Size Doesn't Fit All...

New Humulin 50/50 is the tailor-made answer to individual patient needs. A unique combination of equal amounts of Regular human insulin and NPH human insulin, it will be useful in situations in which a greater initial insulin response is desirable for greater glycemic control.

Like Humulin 70/30*, new Humulin 50/50 offers the convenience and accuracy of a premix. And it can be used in conjunction with an existing 70/30 regimen.



New **Humulin** ⁵⁰/₅₀

50% human insulin
isophane suspension
50% human insulin injection
(recombinant DNA origin)

The Newest Option in Insulin Therapy

WARNING: Any change of insulin should be made cautiously and only under medical supervision.

* Humulin® 70/30 (70% human insulin isophane suspension, 30% human insulin injection [recombinant DNA origin]).



Global Excellence in Diabetes Care
Eli Lilly and Company
Indianapolis, Indiana
46285

HI-7911-B-249343 © 1992, ELI LILLY AND COMPANY

■ letter to the editor

Editor's note: Douglas W. Morrell, M.D., a Rushville family practitioner, sent the following letter to the ISMA expressing his opinions on the OSHA regulations on bloodborne pathogens. Reports from the ISMA field staff indicate that many Indiana physicians share Dr. Morrell's views.

I have just reviewed the new OSHA regulations [on bloodborne pathogens] from a kit I purchased from the American Academy of Family Physicians. The kit was well written but over 500 pages long. It is going to be impossible for my practice to comply with these regulations without hiring another person. I am not going to do this, and this is going to nail a lot of small offices.

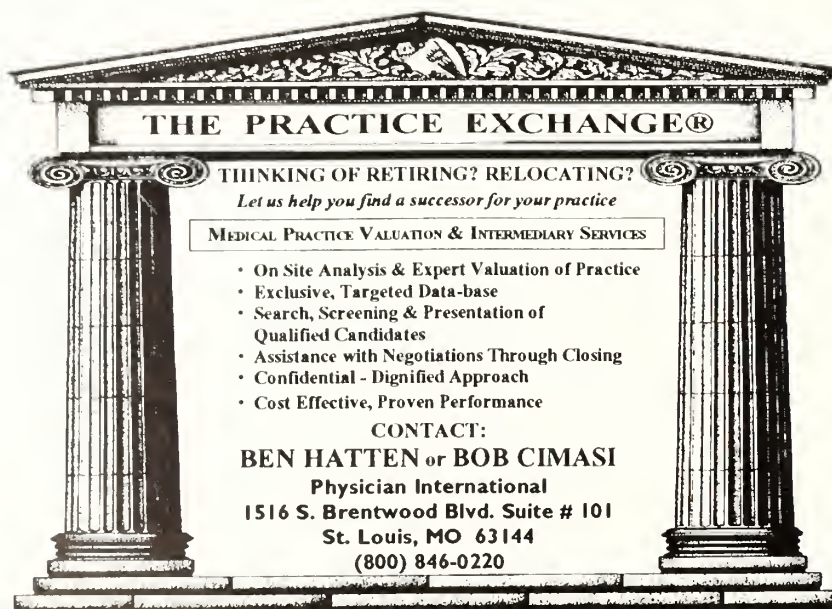
I have decided to immunize my last employee, who had been wary of immunization. We are disposing of our sharps the correct way in plastic containers. We also use universal precautions when dealing with blood products. Other than that, I am saying the heck with the regulations. If OSHA comes in my office and closes me down, then so be it. I can always get another job and am financially secure. It will cause the unemployment of three people, and since no other medical office in town will be doing any better than me, we will all go down the tubes together.

I do not know what the AMA can do about this, but solo and small groups are just not going to tolerate this bureaucratic bumbling. I for one am so fed up that

if the other family practitioner in this medical office building were to leave, I would shut down my practice and work in an emergency room three days a week and make just as much money as I am now with a lot fewer headaches.

There is trouble in River City, and the government is just making it so tough to do business. There is no way a solo doctor could get started today without mega assistance. The costs and regulations are just too great. I would be interested in knowing how some of my colleagues are faring. □

Douglas W. Morrell, M.D.
Rushville



THE PRACTICE EXCHANGE®

THINKING OF RETIRING? RELOCATING?
Let us help you find a successor for your practice

MEDICAL PRACTICE VALUATION & INTERMEDIARY SERVICES

- On Site Analysis & Expert Valuation of Practice
- Exclusive, Targeted Data-base
- Search, Screening & Presentation of Qualified Candidates
- Assistance with Negotiations Through Closing
- Confidential - Dignified Approach
- Cost Effective, Proven Performance

CONTACT:
BEN HATTEN or BOB CIMASI
Physician International
1516 S. Brentwood Blvd. Suite # 101
St. Louis, MO 63144
(800) 846-0220



ARNETT CLINIC

Lafayette, Indiana

About the Multispecialty Medical Group

Arnett Clinic has served Tippecanoe County and surrounding counties in Mid-North Central Indiana since 1922. Arnett physicians introduced the area's first dialysis service, performed the area's first open heart surgery, and developed the community's first heart catheterization laboratory. In seven outpatient facilities, over 95 specialists and subspecialists provide medical and surgical services in virtually every specialty field. The bulk of Arnett's referral patients reside within a fourteen-county area surrounding Lafayette, Indiana, with a drawing area of over 300,000 people.

Ambulatory walk-in clinics in Lafayette and West Lafayette supplement primary clinic services. Arnett Urgent Care Centers are open from 8 a.m. until 8 p.m. every day, and staff members provide diagnosis and treatment for any medical problem which does not require ambulance transport.

Arnett physicians provide hospital support services at two nearby community hospitals, Home Hospital with 365 beds, and St. Elizabeth Hospital with 375 beds. Arnett has diversified into other healthcare fields, including Arnett Health Systems (an HMO) and the corporate affiliates of Arnett Medical Supply and Arnett Pharmacy.

Opportunities

The Arnett Clinic is currently seeking BE/BC candidates:

Cardiology
Dermatology
Family Practice
General Internal Medicine
OB/GYN
Occupational Medicine
Oncology
Orthopaedics
Physical Medicine & Rehabilitation

Practice Setting

At this time, over 95 physicians work for Arnett Clinic. One of the most practical reasons for affiliation with Arnett is the availability of ancillary staff to support clinic operations. Administrative, Laboratory, and Radiology services are available on-site, making our practice environment an integrated, comprehensive, and convenient healthcare resource center. The patient base in Lafayette stems from a balanced mix of industrial and university communities. We are an equal opportunity employer.

Benefits

Our Medical Staff members enjoy competitive salaries and a generous benefit package. During the first two years of employment, Arnett offers a guaranteed minimum salary with a production bonus. After two years of successful practice experience, shareholder status with a productivity incentive formula is available. An excellent profit-sharing and investment plan is also available.

Other benefits include health coverage via Arnett HMO or other group insurance, disability, and life insurance plans. A generous fund for continuing education is available to clinic physicians.

Community

Lafayette, Indiana is a thriving, low-crime community located in a county of approximately 132,000 people. Purdue University, known for academic leadership in the areas of engineering, agriculture, humanities, and sciences, and for Big Ten Sports, is nearby. *Money Magazine* recently identified Lafayette as one of the top 14 cities in which to live in the U.S.A.

For more information, please contact:

John C. Horner
Director of Physician Recruitment
Arnett Clinic
2600 Greenbush Street
Lafayette, IN 47904
(317) 448-8000
Toll Free Nationwide, 1-800-899-8448

National health care: Panacea or Pandora's box?

Editor's note: Rebecca L.

Bushong, M.D., a Muncie dermatologist, was so impressed with the view of one of her patients on the national health care system that she decided to share it with INDIANA MEDICINE.

The view, printed with the permission of the patient, is that of 17-year-old Travis Maurer of Muncie, who Dr. Bushong calls a "very remarkable young man." Dr. Bushong says, "At age 17, Travis unfortunately had more experience with the medical community than most high school students. As he has outlined in his recent essay, he has experienced a brain tumor resulting in hearing loss. Rather than giving in to this unfortunate condition, Travis has become an advocate of the handicapped and has worked diligently for reforms in Muncie."

**Travis Maurer
Muncie**

National health care has been referred to as a panacea for this nation's health care crisis of rocketing doctors' fees, expensive modern technology, excessive medical testing and the large number of uninsured Americans, but "Pandora's box" might be a more justified name for national health care in the United States. National health care might cause large problems for those in need of timely, modern medical treatment.

Timely treatment and modern medical technology have been crucial in the successful removal of a brain tumor that was found on my acoustic nerve growing against the brain stem. While the tumor was not pathologically malignant, its position, size and the fact that it was still growing made it life-threatening. The sur-

geries and the testing were all done at the Indiana University Medical Center in Indianapolis under the current health care system. It is my firm belief that if we had had a national health care plan, such as the Canadians, during this time, I might have died waiting.

Waiting is synonymous with the Canadian health care system; waiting might have made me an unfortunate statistic. Instead of waiting, my physician used an MRI (magnetic resonance imaging) scanner to obtain "pictures" inside the body with a clarity that is unmatched by all other scanning machines and x-rays. The MRI is a \$2 million dollar diagnostic machine (Sochurek 14). It accurately located my brain tumor and its size; the CT scan, a more primitive scanning device, only told the doctors I had a tumor. The MRI, although expensive, actually takes the place of exploratory surgeries. With no side effects, the MRI is also safer for the patient. Because of their high cost, the number of total MRIs currently in Canada is equal to the number of MRIs in the state of Washington (Walker 21). With such scarcity, the Canadians are forced to wait at least two months for an MRI scan.

Although an MRI was not in my hometown of Muncie, Ind., five years ago when I needed it, today one is. After calling Ball Memorial Hospital's MRI department, I found out that the current waiting time in Muncie is one week for a non-emergency scan, and they will see you tomorrow at noon for an emergency scan. Timing and accuracy were very important to the treatment of my tumor. The fact that the United States has more MRI scanners is

evidence of the research and technology advantages in a private insurance system. "The essential feature of the [national] system is that widespread quality deterioration will gradually become a permanent feature" (Walker 23).

The promptness of the removal of my large tumor played an important role in its safe removal. I had a wait of four weeks between the time the doctors found the tumor until its removal. I hate to imagine how long the wait would have been if I were living in a country with national health care like Great Britain. Great Britain had national health care and now, after realizing its mistake, is changing back to a private health care system. In criticizing the British health care system, Rep. Philip Crane of Illinois said in the February 1991 issue of *The American Legion*, "I remember a story of a woman in England who, when the socialized system was intact, was put on a nine-month waiting list to have a heart operation performed." After four postponements due to lack of staff, "the woman died, not able to hold on after nearly a year's delay in necessary surgery." With the government's monopoly on health care in a socialized system, strikes by health care workers affect or even shut down the national health care system (Crane 12). Something is wrong with a country's health care system when the health care workers would rather strike than save lives.

My specialists in neurosurgery and otolaryngology are cautious and competent doctors. In Canada, caution and competency are not always the case. Doctors are forced to work for the Canadian government at fixed rates because the Canadian gov-

ernment virtually holds a monopoly on the health care in Canada. Freed from risk of malpractice suits, Canadian doctors do not always use all the diagnostic tools available to them. American doctors, in fear of malpractice litigations, "seek exhaustive testing to eliminate the probability they will mistakenly reject symptoms of a serious disorder" (Walker 23). This "exhaustive testing" saved me from being misdiagnosed with a virus infection of the ear.

My surgeries, two within a year, cost over \$30,000 each. Luckily, I was covered by my parents' group insurance. Group insurance, according to the transcript from the hearing before the Committee of Finance of the U.S. Senate on June 6, 1991, "works

well for 80% of the employed population." There are those who would say that my surgeries were only performed so promptly because my parents had insurance, but the truth is even without insurance, it have would been possible to go through a government agency called "Crippled Children," a type of Medicaid for uninsured children. Even in America with its private health care system as it is, it is possible for most people who cannot afford insurance to be "insured" by the government (Becker 18).

Americans hope that national health care will be a panacea, but we must consider the "evils" that may be unleashed when opening the national health care box in the United States: long waits for diagnosis, poorer service to the pub-

lic, waiting to see a specialist, decreased technology and decreased research. If the United States had had national health care years ago, this paper would not have been written and my voice would have been quieted forever. □

Works cited

1. Becker, G: Make families cough up for medical coverage. *Business Week*, Sept. 9, 1991.
2. Crane, P: Should Congress establish a national health care system? *American Legion Magazine*, February 1991.
3. Sochurek, H: Medicine's new vision. *National Geographic*, January 1987.
4. United States Senate Committee on Finance. *Conclusion*. June 6, 1991.
5. Walker, M: Should we adopt Canada's health care system? *Consumer Report*, May 1990.

IAFP leader dispels

Bob Carlson
Indianapolis

Almost everyone agrees that we need more primary care physicians.

In its initial conclusions to Congress about medical training in the United States, the Physician Payment Review Commission reports that not only is there a surplus of physicians in the United States but that not enough of them are being prepared for practice outside the hospital.

The Association of American Medical Colleges has formed a task force to propose policies to select students who will pursue primary care and to emphasize primary care in the curriculum.

The Association of Professors of Medicine has endorsed a goal that 50% of all internal medicine residents should be generalists.

The U.S. Bureau of Health Professions recommends that half of all residents should be in primary care by the year 2000.

The Liaison Committee for Medical Education of the American Medical Association and the Association of American Medical Colleges has recommended changes in accreditation standards that would encourage medical schools to offer experience in family medicine, general internal medicine and general pediatrics.

This demand for more general internists, pediatricians and family doctors reflects the consensus of opinion among federal and state health care policy makers that the primary care physician is a key player in a managed care environment. According to this model, an increase in primary care physicians will lead to increased access and lower health care costs.

Unfortunately, the number of medical school seniors wanting to

enter primary care has been declining. In 1982, more than one-third listed primary care as their preference, compared to less than one fourth in 1989. In the nation's most prestigious medical schools, where the emphasis is on high-tech research, student interest in primary care fields is even lower.

For a current perspective on primary care, the role of the primary care physician in the health care provider mix, the reasons for declining student interest in primary care and what can be done about it, INDIANA MEDICINE talked with John L. Haste, M.D., president of the Indiana Academy of Family Physicians.

A family doctor in Argos, Ind., since 1985, Dr. Haste graduated from the Indiana University School of Medicine in 1982. He completed his residency in family medicine at Memorial Hospital in South Bend, where he is currently on the faculty of the Family Practice Center and a preceptor in rural rotation. He is also associate clinical professor in family medicine at the IU School of Medicine in Indianapolis and preceptor of the Third-Year Clerkship in Family Medicine.

Dr. Haste is affiliated with Holy Cross Parkview Hospital in Plymouth, Memorial Hospital in South Bend and Woodlawn Hospital in Rochester, where he has held positions including chief of pediatrics, chief of medical staff, chief of obstetrics and medical director of cardiopulmonary services.

An Indiana native, Dr. Haste was elected president of the Indiana Academy of Family Physicians in August of this year. He is also active in the American Academy of Family Physicians and Argos civic affairs.

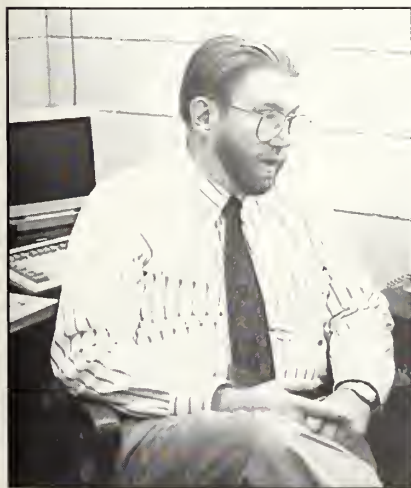


myths of family medicine

INDIANA MEDICINE: What do you see, from your perspective, as the reason for the shortage of primary care physicians?

Haste: I think there are two or three big reasons for that, and I think that one has to come to reimbursement issues right off the bat. The primary care physician has been less than equally reimbursed for the effort that they put in, compared to other specialists.

I think the second thing is that the medical schools have very much pushed specialization in one of the other specialty areas as being more glamorous and being more exciting and being something that you do if you're smart. As medical students, both my partner and I heard, "You're really too smart to go into family medicine. You should be specializing in something else." I think that as the students come along, they make it all the way through medical school and don't really find out what family medicine is about until they've already committed themselves to something else.



INDIANA MEDICINE: So in a sense, they don't know what they're missing.

Haste: I think that's very true. That's what I've found with the students that I've taught up here in the third year rotation [required family medicine clerkship for all third-year students at the Indiana University School of Medicine]. Every one has left here saying, "I had no idea that a family doctor did this much, enjoyed this many things, had this

“*Every one has left here saying, 'I had no idea that a family doctor did this much, enjoyed this many things, had this kind of a long-term relationship with people.'*”

kind of a long-term relationship with people. We have only seen patients at the university setting with the super-sub-specialty people.” Or at least that had been their only exposure in the past. I certainly didn't see doctors who had more than episodic exposure to patients when I went to medical school.

INDIANA MEDICINE: Why is reimbursement for primary care physicians less than perhaps it ought to be?

Haste: For some reason, medical care over the past 20 years has

reimbursed people for doing things instead of thinking about things. I handle somebody's obstetrical care all the way through. I do a complete physical exam, see them for all their prenatal visits, take them all the way through labor, and I get my fee for that. My general surgeon comes in after I tell him that I need a cesarean section, and he gets paid even more for his hour's worth of time at the hospital and two post-op visits, because medical care is being reimbursed for doing things instead of thinking about things. It's so procedure-oriented in its reimbursement.

And reimbursement is a big issue. When you're a medical student and you graduate with a \$50,000 debt or whatever it is right now and you need to pick out a specialty and decide how you are going to get your debt paid off and what kind of lifestyle you are going to have and what's going to be down the road, it's very easy to lean toward anesthesia, radiology, dermatology, cardiovascular surgery. It's not easy to say, well, a surgeon makes as much in an hour as a family doctor does seeing 40 individual patients, so I'll be a family doctor.

INDIANA MEDICINE: How did you get into family medicine?

Haste: It goes back to where I think we need to start and that's kindergarten. I had a family doctor by the name of R.S. Yegerlehner, M.D., who delivered me in Kentland, Ind., who was just a super nice fellow, and I learned that the kind of things that he did were the kind of things that I wanted to do. I started working as an orderly at

George Ade Memorial Hospital when I was 16, unfortunately the only hospital in Indiana that has died, due to health care reforms and Medicare DRGs.

I think that you just develop throughout your lifetime what kind of lifestyle you want and what kind of care you want to give. And I think what happened with me is that I learned around family doctors. I was with them from the time I was 16 working in the hospital, and when I graduated from medical school, I didn't even think about there being other options to me. I knew that obstetrics would be enjoyable, I knew that orthopaedics would be enjoyable, I knew that pediatrics would be enjoyable. Family medicine has them all, so why not do a little bit of each of those? And that's how I decided. I guess I didn't throw economics into the decision-making process because I knew that's what I wanted to do.

I'm not sure how today's medical students start out. I think that we do need to do something better to get people who come from rural communities, who have been around family doctors, who feel like they're going to go into family medicine, and give them some kind of a push into the medical system. We're not doing that now. If you look at the admissions committee at Indiana University, there are only two family doctors on the admissions committee out of all the specialty people.

I think that we need to get ways to identify the students that we think have a higher chance of going into family medicine. There have been some studies that have shown that people that come from smaller communities, people that

have done a lot of volunteer work in high school and in college, are more apt to go into primary care and into family medicine. If we would identify those students and give them some kind of an advantage getting into medical school, it would be more likely that four years down the road you'd have a larger number of graduates choosing a residency in family medicine.

INDIANA MEDICINE: How has the shortage of primary care physicians affected people like yourself, primary care physicians already in practice?

Haste: Personally, I have a very busy practice here. I've had a partner. We graduated from medical school together, did our residency together, came out here seven years ago. He joined the Air Force two months ago, so I'm left with a lot of people that need to be seen, and I only have a certain amount of time to do it in. What you find is that you don't get to spend as much time with the patient, you don't get to touch on the psychosocial issues as much as you would like to. You don't get to spend as much time on preventive medicine as you would like because there are so many people that need health care in the rural communities and there aren't enough of us out here to give it.

INDIANA MEDICINE: How has that same shortage affected patients and the cost of medical care?

Haste: Patients don't get quite as much time with their physician as they would like. They maybe don't get as many questions an-

swered as they would like. They don't get as much preventive medicine as they would like.

If you had readily available family physicians to see them out here in the rural community, they would be apt to have fewer trips to the emergency rooms because they would come in [to the family physician] more often. Preventive medicine would help keep some of the people out of the hospitals.

I think that occasionally people don't get in to be seen if they're a little bit sick and by nighttime they're sicker. They go to the emergency room, and all of a sudden a \$26 office visit turns into a \$200 emergency room visit by the time the emergency room covers itself by getting a chest x-ray and a CBC and a urine on a kid who has an ear infection, whom I would have seen in the office and done none of those things. Yet the emergency room has to prove that the kid isn't worse than what he looks like he is. So it does escalate health care [costs] by not being able to give



acute care and as much preventive medicine as you can.

I think through the 60s, 70s and 80s, we've had this misconception that the health care dollar is inexhaustible. I think we've all come to the realization now that it is not inexhaustible and that we need to redistribute the health care budget so that we can do it in a more cost-effective manner. And several studies show that family medicine is more cost-effective than someone taking their gallbladder to the gastroenterologist and their heart to the cardiologist and their twisted ankle to the orthopaedist.

If I see someone that I'm convinced has esophageal reflux, and that's [what's causing] their chest pain, I can put them on Zantac and give them some Maalox and watch them a couple of days if I feel 95% firm in my diagnosis.

If that very same person stumbles into the cardiologist's office, the cardiologist almost has the burden of proof that nothing else is wrong because he is the pinnacle of care for chest pain. So he has to do a treadmill and if that's maybe falsely positive, he does his thallium treadmill. And a lot of this comes from the legal system, that he has to cover himself. I think that the sub-specialty people have to even practice more defensive medicine because they're the final authority. And all of a sudden, the person that spent \$26 in my office shows up in the cardiologist's office and spends how many dollars more than if he would have stumbled into the family physician's office?

If there are only 13% of us out here doing [family medicine], it's fairly likely that the patient is going to stumble into the

cardiologist's office. But if we go to some kind of system where there are 50% of us out here, and that you have to go to a primary care physician first, we're going to find a significant cost saving to society.

I think the Indiana Academy of Family Physicians needs to help lead the changes in health care because every system that's being proposed says we need more [family physicians]. And I think that the federal government is going to do it if the state doesn't do it.

INDIANA MEDICINE: What can be done to make the primary care

“
We don't need another cardiovascular surgeon in America. We need many more family physicians.
”

choice more attractive to medical students?

Haste: I think that you've got to come back again to reimbursement issues. I think that going into family medicine should be rewarded in just the same ways as a cardiovascular surgeon is rewarded. This isn't the Academy feeling, probably, but my personal thought is that it's not so much that we have a lack of health care resources spent on physicians as much as an unequal distribution of health care resources for physicians.

INDIANA MEDICINE: What do you mean by the allocation of health care resources?

Haste: Reimbursement. To have family practice become more of an option for medical students right now, they have to, number one, see that there's no difference in reimbursement, that they aren't going to take a "pay cut" to become a family doctor. Because that's what America needs. We don't need another cardiovascular surgeon in America. We need many more family physicians. We've got 13% family medicine out here and we need 50% if we're going to give people the kind of cost-effective, high quality, easily accessible health care that Indiana deserves.

INDIANA MEDICINE: Any factors that come a close second to the issue of reimbursement?

Haste: Exposure. I was exposed [to family medicine] all the way through my young formative years, in high school and in college. I think that we've got to do that. We have to do it starting at the very beginning. Tomorrow, the kindergarten class will be here in the morning and in the afternoon. They'll look at x-rays on my view box and see where my son broke his arm and how I straightened it out and cast it and fixed it and that we do things for everybody, all kinds of medical care here. We explain about what it's like to be a doctor and what his normal day is like. I do it obviously from the perspective of a family doctor and don't tell them that radiologists exist, in kindergarten. I figure they'll find

that out later as they go along. I'll talk with the first graders and the third graders on career days about what a family doctor does. And we do that in junior high, and we do it in high school. I think we need to start that early in the educational process, getting kids to understand that family medicine is a very enjoyable, very rewarding profession that they might want to pursue.

In medical school, I think we need to really get them earlier than we are now. As I said before, two of the three [medical students] that have come here at the very onset told me that they were not interested in family medicine, that was not their career choice. I have a great letter here from the last one: "... my month in family medicine was the deciding factor ... wider patient population, warm doctor-patient relationship, variety of fields provided a stimulating, enjoyable working environment. I was excited to see the family practitioner interact so well with patients and contribute so much to the small community. The service that family practitioners provide is a role that I hope to fulfill someday."

She went from someone who was not going to be a family doctor to, in four weeks time, deciding that she wanted to really give this a chance. She did a couple of rotations in family medicine in her senior year, and she's going to apply for residencies in family medicine. I think that if she'd never had this experience, she wouldn't have realized all the rewards you reap as a family physician.

There are two kinds of perceptions medical students have that I'd like to get rid of. One is

that some medical students think that family doctors do triage. When [my last medical student] first started her month she said, "I thought you would see somebody that was having post-menopausal bleeding and you'd refer them to the gynecologist. I thought you would see someone who had an infected sebaceous cyst and you'd send them to the surgeon. I thought you'd see somebody who's having an acute heart attack and you would send them to the cardiologist." Well, we don't have a cardiologist. She said, "You removed the sebaceous cyst. You did your own D & C. The kid that fell off the monkey bars over here, you reduced his fracture and cast it. I thought that

“
We need to start ... getting kids to understand that family medicine is a very enjoyable, very rewarding profession that they might want to pursue.
”

family doctors were triage people. When I left here, I realized that 90% of the problems that walked in your front door, you took care of, and you took care of them well, and the patient did well. That's what really, really changed my perspective of what family doctors were."

The second misconception is just the opposite, that family doc-

tors have to learn this huge volume of literature. [Some students think family doctors] have to memorize *Cecil's Textbook of Medicine*, the pediatric book, and that they have to know everything inside and out, that they're on call 24 hours a day, that they never get any sleep, that they are always responsible for their patients. [This is] the overworked type image that came from the family practice GP's that were in practice 20 to 30 years ago.

But that's not the case now. If you really look, most everybody that graduates from residency programs goes into a group of three or four people. So they get to have a family life. You don't have to stay up every night. Maybe every fourth night you're bothered, or every third night. You do have time to watch your kids play baseball and grow up. Yes, there is this huge body of knowledge out here and we need to know what we use very well. We need to know what we don't know and who knows it and refer the ones that are appropriate to refer.

So these are two ways that I



think medical students view family medicine that are not the true picture, and both are pretty well perpetuated by the medical school experience because they don't get out here to see us. If two-thirds of the people that I've taken into my office have seen some difference in their perception of what a family doctor does, I think we need to even get them earlier.

Two years ago we started the senior selective at IU, and we got a few that way. And then this past year was the junior year required four-week rotation [in family medicine]. I think we need to really work hard on getting medical students between their first year and their second year out in family doctors' offices, even if it's just for a month, to live with a family doctor and see what's going on. I think we could increase the number of students that choose family medicine. Because if you stay at the medical center, you hardly even hear about family doctors at all.

INDIANA MEDICINE: Obviously you're enjoying considerable success in correcting some of these misperceptions. Is this something that the Academy is pursuing or are we just talking about Dr. John Haste here?

Haste: No, we're talking about the Academy. We were very supportive of the dean [of the IU School of Medicine] choosing to

have this rotation. You will find that almost all the preceptors in this junior rotation are board-certified, residency-trained, family physicians who are members of the Indiana Academy of Family Physicians. We're a force out here that is voluntarily teaching these medical students in their junior year.

The Indiana Academy of Family Physicians activated a foundation trying to find some moneys so that we can make a rotation available for medical students between their first and their second year, placing them out with family doctors. We're trying as an Academy to get medical students more exposed to family medicine. We started a student mentor program where any medical student that wants to become a member of the Indiana Academy of Family Physicians and the American Academy of Family Physicians will be matched up with a family doctor. We'll pay their dues, we'll call them up on the phone and answer questions, have them come and spend time in the office, any time they wish. Our student mentor program has met pretty good success.

INDIANA MEDICINE: What would you say to recommend family medicine to a person who is considering options?

Haste: The biggest gratification is the personal interaction with the

entire family. The medical student here this month with me and I recently saw a great-grandmother who has multiple myeloma. About an hour and a half later, we saw the great-grandson who I admitted a couple of weeks ago for meningitis. Mother and grandmother both were in later that afternoon. Here we saw four generations of a family and how they interact all in the same day. Now, it's unusual that I see that many [family members] all in the same day, but there's hardly anyone in my practice that I don't know the extended family. When I realize that they're having problems with one thing, I can see how that affects them and their grandparents and the whole process of the family. Because that's what we're here for. We're trying to take care of an entire family unit and make their life better.

At the medical school, students learn to treat diabetes. Family physicians don't just treat diabetes, but treat a person who has diabetes, not only as a single entity but in the context of their family unit, not as an episodic encounter but over a long-term relationship with this entire family. Being involved in this type of relationship can give gratification far beyond just treating diabetes. □

This interview was conducted by Bob Carlson, a health care communications consultant in Indianapolis.

Vagueness of OSHA rules concerns physicians

Kurt Ullman
Carmel

In December 1991, the Occupational Safety and Health Administration (OSHA) published sweeping new regulations concerning control of bloodborne pathogens in work settings. Although this standard has an impact on all employers, the health care industry will be particularly affected. Government officials estimate it will prevent 200 deaths and 9,000 bloodborne infections annually.

"This standard is in place for all workplaces, not just health care," said Tony Kuritz, industrial hygiene consultant with the Indiana Department of Labor. "Even tow truck drivers who may have to get inside a car after a bad accident are covered."

The regulations require employers to formulate and provide training on employee exposure control plans. There are specifications for provision of personal protection equipment, housekeeping and post-exposure evaluations. It also mandates implementation of universal precautions. Each of these regulations come with its own set of paperwork and reporting tasks.

"For the most part, these regulations are an unnecessary expense," said Daniel Anderson, M.D., a Salem internist. "A doctor's office is not a factory and we do not hire people directly off the street. The people who work for me are professionals who already know how to do their jobs and that includes keeping them-

selves and our patients safe."

Many physicians view the regulations as redundant. Doctors have long had policies in place to deal with bloodborne pathogens as part of their infection control plans.

"In our practice, we were already doing everything required before the regulations came out," said Steven Yoder, M.D., a family practice physician in Goshen. "For a long time I have included a yearly lecture on AIDS and blood spill control for the staff. From my standpoint, all it did was require us to do some more paperwork, which costs us time and money."

Others tend to agree. The largest impact may be in completing forms instead of adding safety.

"We always are very careful and judicious in maintaining precautions and disposal of medical wastes even before the regulations became effective," said Susan Harmeyer, business manager for Drs. Geoffrey Randolph and Aaron Borenstein, plastic surgeons in Fort Wayne. "It has mainly meant more money going out for bags, stickers and things of this nature."

Concerns were voiced by many over the costs to the physician and patient associated with these regulations. The government has estimated outlays of \$1,179 annually for the average doctor's office. However, the true extent of the expenditures is still unknown.

None of those interviewed has had to hire extra full-time workers to comply with the requirements.

Most of the smaller offices said they were using their part-time help more hours a week. One physician estimated that 10 extra hours a week were being worked by his staff because of the standard's requirements.

Another impact is loss of services to the people. There may be delays getting patients into the practice or seeing them on short notice. Doctors may work longer hours to help lessen this effect.

"We don't really know yet what the impact will be financially, but I do know that it will most likely exceed what the government estimated it would," said Harmeyer. "I'm going to have at least \$2,000 just in protective clothing to start with. To maintain that on a yearly basis is an ongoing expense that I have not yet been able to accurately estimate."

She currently is expecting outlays in her small office of between \$2,000 and \$4,000 yearly. Her figures do not include revenue losses caused by seeing fewer patients because of staff time required to fulfill obligations imposed by the rule.

"My direct costs have run about \$1,375 in preparing to begin this program," said Dr. Anderson. "This does not include loss of productivity and staff time to attending seminars, writing the required manuals, or doing the staff teaching. It also misses ongoing outlays for cleaning, annual refreshers and reporting requirements."

Dr. Anderson cited a kit he was required to purchase to clean mercury spills. This \$20 outlay

was mandated in case his mercury-filled blood pressure instruments leak.

Many physicians see the burden of the new regulations falling to a large extent on the shoulders of their employees. For example, if blood needs to be drawn, nurses are the ones who are going to have to don protective clothing before performing the procedure. Many employees believe the new requirements will disrupt staff routines and greatly decrease efficiency.

The requirements that lab coats be changed before leaving an area and that face shields be used when drawing blood add to the time it takes to do the procedure. The result is that either more office time and expense or fewer patients will be seen.

"You have to look like someone from outer space before you can approach a patient," said Harmeyer. "What they are asking is not going to work for the most part for those who take care of patients."

Some see the possibility that the regulations may well have the opposite effect. They introduce new techniques that nurses or aides are not used to performing. This may cause additional mistakes.

"Our physicians and staff feel that the requirements are good, and we should have been doing them anyway," said Rodger Pinto, Ph.D., clinical service director for Nasser, Smith and Pinkerton Cardiology in Indianapolis. "Where there are the most difficulties is in the area of exposure. Then they

feel it gets a little excessive."

In these cases, OSHA requires that blood from both the patient, if consent can be obtained, and the staff member be tested. There are also requirements for counseling of the staff member by a physician. The rules as currently interpreted do not differentiate between a skin prick and major contamination from a severed artery.

"Three of our people have had exposures, two needle pricks and a splatter," said Pinto.

Many physicians see the burden of the new regulations falling to a large extent on the shoulders of their employees.

"Those people have had medical workups that cost us around \$100 each."

The requirements for AIDS testing are even more expensive. Blood must be drawn three times over the course of a year. Physicians must be available to counsel the staff member. Often this is interpreted to mean specialists from outside the practice.

Some physicians are studying which procedures are still economically possible within the office setting. It is possible that a variety of interventions may have to be switched to a hospital or other surgical facility.

"I am looking to possibly transfer some procedures I used to do in the office back to the outpatient department at the hospital," said Dr. Anderson. "This is more expensive to the patient

and the system, but they have more people using the facilities and can better absorb some of the extra costs involved."

Among the procedures currently being evaluated include excision of skin lesions and sigmoidoscopy. The time it takes to clean equipment when combined with the expense of mandated garments makes it too burdensome for the physician to continue doing some of these in the office.

A common concern has been the length and vagueness of the final rules. When considering the fines and other penalties at OSHA's disposal, all agreed that this was the part that worried them the most.

"The OSHA law runs to more than 100

pages of regulation," said one Indiana physician who asked to remain anonymous. "We are already so inundated with insurance forms, third-party documentation and other paperwork requirements, how could anyone know what the law is? Even the regulators will give you different answers depending on whom you talk to."

There is no consensus even among experts about what the standards mean. Some doctors complained that staff had attended different seminars, getting different answers to the same questions.

One physician said he was told that an OSHA representative was asked what the inspectors would be looking for when they survey the office. They were allegedly told it depends on the

kind of day the person doing the visit was having.

"I think I understand about 90% of what we are supposed to be doing to comply," said Dr. Yoder. "There are probably little things that they can find wrong. The most important thing is that my staff is protected."

A large part of the published standard is preamble, and the actual guideline itself is about 10 double-sided pages in length. After eliminating the justifications, the economic impact statements and other boilerplate legal requirements, the burden actually placed on the physician is less than it seems, according to Kuritz.

Another substantial section is a codification of the universal precautions guidelines from the Centers for Disease Control, Kuritz explained. Health care providers should have been following these before the rules took effect.

"We have been getting many telephone calls from the factory owner about universal precautions and medical waste disposal for their first aid people," he said. "They have never had to do this, while infection control has been a medical priority for years."

Many of those interviewed have reinforced the other perception. Even consultants called in by the various practices have consistently stated that their suggestions are not carved in stone. If OSHA does not interpret the regulations in the same way the consultants did, physicians may be at risk for stiff fines.

"We are still trying to inter-

pret what we really need to do to comply with the standards," said Harmeyer. "There still isn't a lot of concise information available. What there is remains vague and leaves much to individual interpretation."

Retaining and storing the records required by the standards has the potential to become a nightmare. Training records must be maintained and made available for inspection by OSHA or the employee for three years. Others types have even longer requirements.

Retaining and storing the records required by the standards has the potential to become a nightmare.

"Now you basically have to keep some records for life," said Pinto. "If there is exposure, you have to save the documents for 30 years after a person leaves your employ. If someone works for 20 years, that record may be as much as 50 years old before it can be discarded."

A concern voiced by many is that the inspector may not be focusing on the proper things should a visit to a doctor's office occur.

"I get the feeling that as long as the paperwork is there, everything will be all right," said Dr. Yoder. "Whether we have really taught our staff how to do it well and protect themselves, the government doesn't seem to care about that. We had done all of

this before, so I'm just irritated by more regulations."

Those interviewed say there are many areas that need to be clarified. Among them is the requirement for prophylaxis if exposed to bloodborne pathogens.

"What does that mean if a person is exposed to AIDS?" asked Pamela Bloch, R.N., clinical administrator for Nasser, Smith and Pinkerton. "There is really no prophylaxis for AIDS, but because of this rule, hospitals and others may feel the need to prescribe AZT. The language is so strong that you feel required to do something, even if there is nothing to do."

The guidelines used for carrying this out will be the same no matter what type of industry is involved. In fact, Kuritz stressed that there is no special program by OSHA that targets doctors' offices.

Usually there are two scenarios when inspectors would go into an office. One is in response to a specific complaint. The other is a "wall-to-wall" inspection of a facility. Under OSHA guidelines, there would seldom be a major survey of a doctor's office because it is not considered a high-hazard workplace.

There seems to be a consensus among those interviewed that some specialties may have fewer disruptions than others. Size may be a factor, too.

"Family practitioners may have an advantage in this area over surgeons who do many in-office procedures," said Dr. Yoder. "The impact on a general surgeon may be more due to the level of invasiveness and the actual num-

ber done."

Typically, the larger practices were able to implement the regulations with fewer problems. The extra staff available to work on parts of the whole made the task less cumbersome.

"We employ over 200 people, including the physicians," said Bloch. "It took a tremendous amount of time to set it up, but we had the management personnel available to get it done with a minimum amount of trouble."

Many physicians noted that they were getting brochures and mailings touting OSHA-approved supplies and equipment long before the rules were published. The rules have spawned a new industry selling gloves, gowns and regulatory knick-knacks.

Sorting through the deluge to find what was really needed added to the confusion. Most physicians turned to a nearby hospital and used their specifications as a base from which to

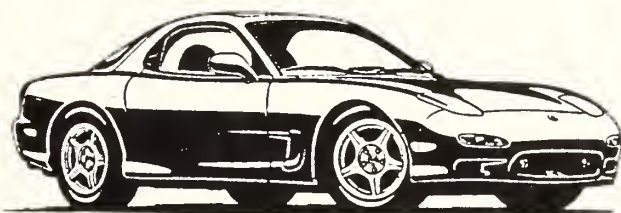
work.

"I don't think the regulations have been thought out well enough to really protect people and the workplace," said Harmeyer. "It is going to cost businesses more than it is going to produce and ultimately die a slow death." □

The author is a registered nurse and the owner of Medical Communicators, a Carmel-based medical editorial consulting firm.

MAZDA

THE RETURN OF THE PURE SPORTS CAR. THE ALL-NEW 1993 RX-7.



- 255-HP Twin-Rotor Incline Rotary Engine
- Sequential Twin Turbo Charger
- Drivers Side Airbag
- Anti-lock Brake System (ABS)
- 0-60 mph: 4.9 seconds
- Special Lease Plans Available

Find out for yourself today at Indiana's #1 Mazda Dealer!

Speedway Mazda • VW • Subaru • 1930 W. 16th St., Indpls., IN 46202 (317) 263-0002

WE SELL FOR LESS AND PROVE IT EVERYDAY!

HIV/AIDS surveillance in Indiana

Mary Lou Fleissner, DrPH
Indianapolis

The second decade of the AIDS epidemic began amidst many controversies and the awareness that the pandemic is escalating both in the United States and worldwide. In the United States, the first 100,000 AIDS cases were reported over a nine-year period, while the second 100,000 cases were reported in a little more than two years, September 1989 through November 1991.¹

Figure 1 is a snapshot summary of AIDS reporting for 1991. As sobering as these statistics are, they are overshadowed by the estimates of HIV infections. In 1981, about 100,000 people in the world were infected with HIV. At the beginning of 1992, an estimated 12.9 million people worldwide had been infected, including 7.1 million men, 4.7 million women and 1.1 million children. Of these, about one in five already have developed AIDS, with many of these already dead.²

Although Indiana ranks 23rd in the United States in the total number of AIDS cases reported through June 1992,³ the AIDS epidemic in Indiana is expanding. As of the end of August 1992, 1,621 cases of AIDS had been reported to the Indiana State Department of Health (ISDH). Since the reporting of AIDS cases lags behind the diagnosis of AIDS in Indiana by about six months, and since only about 67% of the cases in Indiana are believed to be reported, it is likely that more than 1,900 cases of AIDS have occurred

in Indiana thus far. Of the 1,621 cases that have been reported, 62% of the patients have died.

It is impossible, however, to judge the impact of the HIV/AIDS epidemic on the basis of reported AIDS cases alone. AIDS is just the end of the spectrum of HIV-related disease. Since the incubation period may extend 10 years or more, cases of AIDS reflect transmission patterns of the past. People reported with HIV infection are more likely to have an infection that was more recently acquired and, therefore, reflect more recent trends in HIV transmission.

Indiana is one of 24 states that require confidential reporting by name of HIV-infected people to the state health department.⁴ Comparison of the characteristics of people who have been reported with HIV infection with people

reported with AIDS can give insight into the changing epidemiology of the HIV/AIDS epidemic. In Indiana, separate registries are maintained for HIV infections and AIDS cases. Both of these registries have limitations that prevent reliance on either one alone to describe the HIV/AIDS epidemic. Although reported HIV cases may not represent all HIV-infected people, they provide a minimum estimate of the number of people in need of health care and other services and indicate characteristics of future AIDS cases.

Surveillance data in Indiana indicate a trend toward increasing numbers of women infected with HIV and subsequently developing AIDS. The proportion of all cases who are women is increasing. Figure 2 shows trends on the proportion of cases of HIV/AIDS that are females.

Figure 1

Based on surveillance statistics for 1991



In Indiana:

- A new case of AIDS was reported every 25 hours
- A person died of AIDS every 40 hours



In the United States:

- A new case of AIDS was reported every 12 minutes
- A person died of AIDS every 16 minutes



In the world:

- A new case of AIDS was reported every 4 minutes

Source: Wisconsin AIDS/HIV Update and the Indiana State Department of Health

Figure 2

Females as percent of total adult/adolescent
diagnosed cases in Indiana

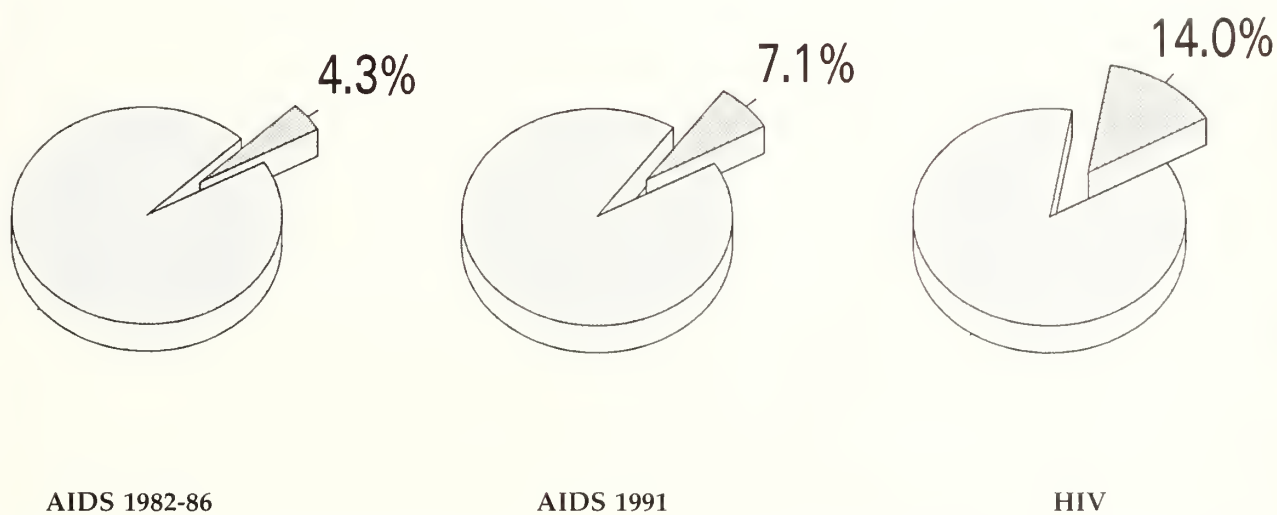
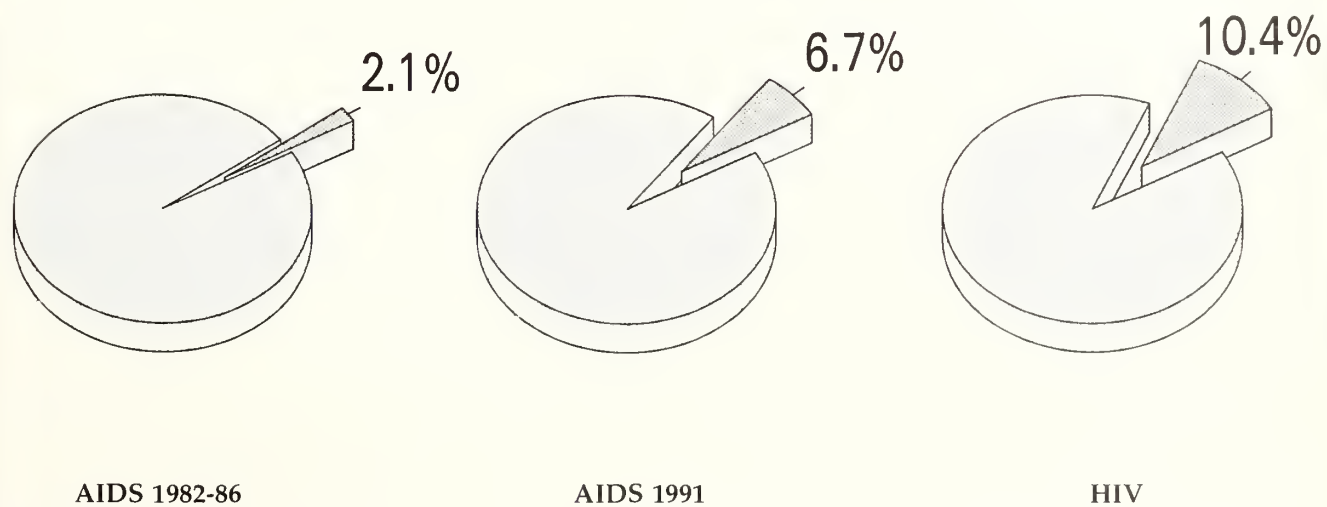


Figure 3

Heterosexuals as percent of total adult/adolescent
diagnosed cases in Indiana



As the epidemic in Indiana includes more women, the epidemic also will involve more pediatric cases. Through August 1992, only 14 pediatric AIDS cases have been reported in Indiana. However, 35 pediatric cases of HIV infection have been reported.

The HIV/AIDS epidemic in the United States has disproportionately affected minority populations. This trend also has been observed in Indiana. Comparing the racial group of those with HIV infection to those with AIDS in Indiana indicates that HIV infection is even more excessive than AIDS cases among the black population (*Table*).

Other changes that are evident in comparing the two registries is the emergence of heterosexuals as a group increasingly at risk for HIV/AIDS in Indiana. *Figure 3* demonstrates that heterosexuals accounted for only 2.1% of the total AIDS cases in Indiana in the early stages of the AIDS epidemic, but account for 10.4% of those with HIV infection for whom a risk behavior has been identified. People with intravenous drug use as a risk behavior account for only 8% of the total AIDS cases in Indiana, but 17.3% of those with HIV infection.

Reviewing the surveillance systems indicates that at least one person with either HIV infection or AIDS has been reported from 91 counties in Indiana. Through the end of August 1992, two counties have accounted for 50% of the AIDS cases; Marion County, with a population of 797,159, has reported 41% of the AIDS cases (672), and Lake County, with a population of 475,594, has reported 9% of the AIDS cases (139). These two counties also reported

45% of the Indiana cases of HIV infection. However, Lake County had a 1.9:1 ratio of HIV cases to AIDS cases, while the ratio of reported HIV cases to AIDS cases in Marion County was only 0.8:1. Since there are more people who are HIV-infected than have already developed AIDS, data from Marion County indicate disparities in the reporting of these two conditions.

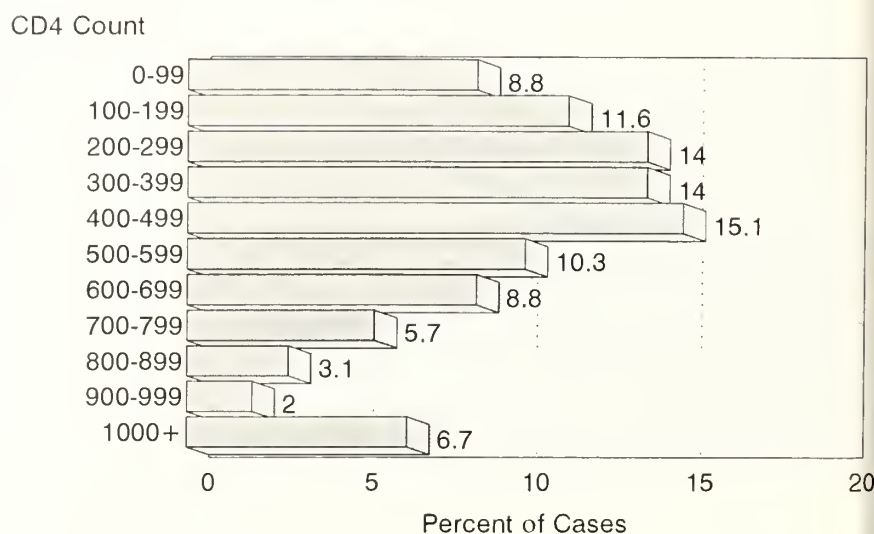
The case definition of AIDS is one of the more prominent controversies of the HIV/AIDS pandemic. Since 1981, when the acquired immunodeficiency syndrome was first recognized as a distinct medical condition, the case definition for the surveillance system in the United States has been revised four times. A new case definition, which would in-

clude people HIV-infected with a CD4 count of less than 200 cells/ μ L, was to have been implemented Jan. 1, 1992, by the Centers for Disease Control (CDC). The CDC estimated that this proposed case definition would have doubled the current number of AIDS cases.

The implementation of the case definition has been postponed several times, and alternate criteria have been proposed for the revised case definition. If the criteria for revised AIDS cases definition ultimately include people HIV-infected with CD4 cell counts of less than 200 cells/ μ L, states that already receive reports of HIV infection would be in a better position to add cases to the AIDS surveillance system. These states would be able to use the

Figure 4

Reported CD4 counts among people reported with HIV infection (excluding AIDS) in Indiana (N=614)



Table

**Percent of HIV/AIDS cases by racial group in Indiana
(1982 through Aug. 30, 1992)**

	Population of Indiana (%)	AIDS cases	HIV infected*
White	90.7	79.6	68.9
Black	7.8	18.4	27.5
Other	1.5	2.0	3.6
N =		1,621	1,803

* Percent with known race

HIV registry to search for cases that fit the new AIDS case definition. In Indiana, of the 1,847 people reported with HIV infection, 33% had at least one CD4 count reported (Figure 4). Among reported HIV-infected people with a CD4 count available, 20% (125 people) have counts of less than 200 cells/ μ L. These people would qualify as AIDS cases under the proposed new case definition.

Most HIV/AIDS experts agree that the AIDS definition needs to be revised. There are numerous reasons for the revision, but from the surveillance perspective, the current definition does not mea-

sure the true impact of the disease, nor does the surveillance system of current AIDS cases reflect the transmission trends that are associated with HIV infection. In order for a surveillance system to be effective, reporting needs to be timely and as complete as possible or at least be free of reporting biases.

Surveillance data are useful for many purposes. Monitoring the epidemic and targeting health education, risk reduction and early intervention programs are some ways to use the data in the HIV/AIDS program. Although male homosexual transmission of

HIV is still associated with a large portion of cases of HIV and AIDS reported in Indiana, increasing morbidity is demonstrated among younger people, women and children, heterosexuals, intravenous drug users and racial minorities. Improving the surveillance for both HIV infection and AIDS will help obtain funding for programs, plan future health care and other needed services and plan and implement education and prevention programs for those affected by this epidemic. □

Correspondence: Mary Lou Fleissner, DrPH, Indiana State Department of Health, Epidemiology Resource Center, 1330 W. Michigan St., Indianapolis, IN 46202.

References

1. Centers for Disease Control: The second 100,000 cases of acquired immunodeficiency syndrome - United States, June 1981 - December 1991. *MMWR*, 41:28-29, 1992.
2. Mann, J: *AIDS in the World 1992: A Global Epidemic out of Control?* Boston: Global AIDS Policy Commission, June 3, 1992.
3. Centers for Disease Control: *HIV/AIDS Surveillance Report*. July 1992:1-18.
4. Centers for Disease Control: Public health use of HIV - Infection reports South Carolina, 1986-1991. *MMWR*, 41:245-249, 1992.

Helping patients receive Social Security benefits

Steven K. Robison, J.D.
Seymour

Social Security disability cases can be frustrating for physicians. Often, I hear physicians say, "This patient is just too young to get disability," "I've given Social Security everything I've got on him; they just won't believe me when I say he's disabled," or "I've told Social Security I think she's disabled and can't work; what more do they want?"

The short answers to such comments and questions include:

1) Nobody is denied Social Security disability just because of age, although age, understandably, plays a role in the disability evaluation process.

2) Social Security disability is based on medical evidence and on the interpretation of medical evidence. Merely giving Social Security a copy of your files and saying the patient is disabled often is not enough. You may have to interpret the evidence you give Social Security. Also, your file may be missing a crucial element needed by Social Security to establish your patient's disability.

3) Nobody is granted Social Security benefits just because the treating physician believes the patient can't work. Social Security is interested in why the physician believes the patient is disabled, including restrictions the patient has that lead the doctor to this conclusion and the medical explanation of the conditions leading to those restrictions.

This article is a brief guide for

physicians on the considerations that Social Security focuses on and how physicians can help their patients receive favorable treatment from Social Security under those considerations.

Defining disability

What does it mean to be disabled under Social Security? Disability is the inability "to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment, which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months."¹ This definition does not require the claimant to be bedridden or be a "basket case" to qualify for disability.

However, the definition is an "all or nothing" approach to disability. Social Security does not recognize partial disability. A claimant is either disabled or not disabled; there is no middle ground. The percentage ratings in workers compensation cases do not apply, and are only confusing in Social Security cases.

It is possible to be disabled, for Social Security purposes, for a definite time period. An example is a patient who makes a slow but complete recovery after an automobile accident. This is called a "closed period" case.

Eligibility standards

While no two Social Security cases are alike, all Social Security cases, both Title II (disability) and Title XVI (SSI) cases, are evaluated under a five-step analysis, which proceeds until benefits are

granted or denied.² Although eligibility standards differ for these programs, the medical standard for disability under each is the same.

The five-step analysis asks: 1) Is the claimant working? 2) Does the claimant have a severe impairment? 3) Does the severe impairment meet or equal a Listing impairment? 4) Can the claimant perform past relevant work? and 5) Can the claimant perform other work existing in the economy, considering his age, education, work experience and impairments?

Step 1 is fairly basic. If a claimant is still working regularly and making more than \$500 per month on average, the claim will be denied.³ Earnings between \$300 and \$500 per month on average may result in a denial of the claim.⁴ This step has no medical considerations.

Step 2 focuses on the nature of the impairment for a claimant who is not working. Impairments must be assessed in combination and not serially.⁵ With multiple impairments, it is possible that none is disabling in itself but that the combined impairments would produce a finding of disabled. A "severe" impairment means the impairment reduces the person's residual functional capacity.⁶ If the impairment is not severe, the claim will be denied. This step involves both medical and vocational considerations.

Step 3 is exclusively medical in nature. Appendix 1 of the Social Security regulations contains the adult listings. These are impairments that Social Security

recognizes as severe enough that, if one or more is met or equaled and the claimant is not working, the claim is granted. Medical evidence is required to support a listings case – a statement that “John Doe meets Listing 1.05(C)” isn’t enough. Why does John Doe meet that Listing? What condition(s) does he have that leads to that statement? Many of these Listings require objective test results according to a set protocol. Those test results and your interpretation of them should be included in any case in which a patient may meet or equal a Listing.

Meeting the Listing criteria involves matching the criteria exactly.⁷ If a patient does not exactly fit the criteria, but the severity of his condition is equal to that described in a Listing, a patient may equal the Listing criteria.⁸ Benefits will be awarded in these cases.

The impairment does not have to be of the same type as that described in the Listing if the severity is the same.⁹ For example, in one case, a medical witness stated that a patient equaled the Listing for *tabes dorsalis*. The patient was diabetic with rather severe end organ damage, leading to an uneven gait matching that described in the *tabes dorsalis* Listing. However, the patient did not have syphilis.

Step 4 focuses on the claimant’s ability to perform work that he has performed within the last 15 years and has performed long enough to learn to do the

job.¹⁰ This step involves both medical and vocational considerations. Social Security looks for medically documented restrictions, such as limitations on sitting, standing, lifting, bending, stooping, climbing, reasoning, thinking and intellectual functioning, that preclude the claimant from performing past relevant work. Again, medical opinion, standing alone, does not help; medical evidence is required.

In a recent survey I conducted while preparing an article on medical evidence, I asked several Social Security administrative law

It is fine for a physician to say, for example, that a patient can't work or can't sit longer than 15 minutes without lying down, but the physician needs to provide the medical basis for that opinion, as well.

judges what type of medical evidence they found unpersuasive. Several judges said they were not persuaded by the short statements from treating physicians, sometimes written on prescription pads, that the claimant was disabled, without any supporting evidence. It is fine for a physician to say, for example, that a patient can’t work or can’t sit longer than 15 minutes without lying down, but the physician needs to provide the medical basis for that opinion, as well. Include any objective test results supporting the opinion.

Step 5 is reached when the claimant is not working, has a

severe impairment that does not meet or equal a Listing and is precluded from past relevant work.¹¹ Most Social Security cases are resolved at Step 5. This step focuses on the residual functional capacity of the claimant, and considers his age, education and work experience, with the inquiry being whether there are other jobs that the claimant can do. The determination of residual functional capacity is a medical question; medical evidence is required to support the determination.

Where the claimant’s limitations are only exertional in nature or where no nonexertional impairment significantly affects the claimant’s ability to perform work at a given exertional level, Social Security may use “Grids” to determine disability.¹² Grids are an administrative short-hand for making a disability determination and consider age, education and work experi-

ence, as well as the claimant’s residual functional capacity. This is the only step at which your patient’s youth may work against him; if a claimant can exertionally perform the full range of sedentary work, is under 45 and has no significant nonexertional impairment, he will not be found disabled, regardless of whether he is illiterate or unable to speak English or has never worked.¹³

With younger claimants, it is important to develop non-exertional impairments that significantly affect the claimant’s residual functional capacity. This will prevent Social Security from using grids to deny benefits.

Nonexertional impairments include: illiteracy, learning disabilities, vision problems, missing fingers, lack of bilateral dexterity, pain present even at rest (pain can be exertional or nonexertional or both), substance addiction or abuse (drug addicts and alcoholics can qualify for disability if the conditions are medically documented), and mental impairments.¹⁴

Know the definitions

Be careful when you try to qualify a patient's condition with phrases such as "light work only" or "should retrain for a sedentary occupation." Sedentary and light work are defined in Social Security regulations and may be more restrictive than you might think. For example, sedentary work involves work predominantly seated and can involve lifting of up to 10 pounds, as well as occasional walking and standing and carrying of small objects.¹⁵ Light work involves frequent lifting of up to 10 pounds and occasional lifting up to 20 pounds and can involve standing, walking and using overhead switches or gears and foot controls or pedals.¹⁶ Can the patient perform all of these tasks within either of these classes of work? If not, the use of these terms, without knowing the full impact of them, can be harmful to a patient's claim.

Throughout this article, I have referred to "medical evidence" required to support a claim for disability benefits. Social Security channels medical evidence into categories of symptoms, signs and laboratory findings. Symptoms

are the claimant's characterization of his disability.¹⁷ Symptoms count only in connection with signs and laboratory findings.

"We will never find that you are disabled based on your symptoms, including pain, unless medical signs or findings show that there is a medical condition that could be reasonably expected to produce those symptoms."¹⁸

Signs are anatomical, physiological or psychological abnormalities observable apart from the patient's symptoms.¹⁹ They must be supported by medically acceptable clinical diagnostic techniques.

Laboratory findings are anatomical, physiological or psychological phenomena that can be

that you would place on a patient).²² This assessment often can be done using a checklist.

Providing medical evidence

With a little extra effort, you will find that you can provide Social Security with the medical evidence it needs to reach a favorable decision on your patient's disability claim. Consider the differences in these two reports:

Example 1 – "John Doe is my patient. He has crippling arthritis in his hands, shoulders and hips and cannot work. He is totally and permanently disabled."

Example 2 – "John Doe has been a patient of mine for three years. I first saw him Oct. 1, 1989, and have treated him an average of once a month since that time. I last saw him Aug. 28, 1992. Mr. Doe has degenerative arthritis in both hands, both shoulders and both hips, which is severe. It was severe

when I first saw him and has remained consistently so. The diagnosis is confirmed by x-ray studies done Oct. 4, 1989; Dec. 5, 1989; and May 6, 1990, (attached). I have prescribed [list medicines] for relief of the symptoms, which include joint limitation, stiffness and pain.

"This type of arthritis, at this severity, can be quite painful, and I have no doubt that the complaints of pain from Mr. Doe are attributable to the arthritis. Mr. Doe reports (and Mrs. Doe confirms) that he has substantial difficulties with dressing, bathing and simply getting around the house. The arthritis in the hips has produced a gait deformity; Mr. Doe noticeably limps on the right side and has significant difficulty

An unsupported conclusion that a patient can't work is not enough.

shown by medically acceptable laboratory diagnostic techniques, including x-rays and electrocardiograms.²⁰

An unsupported conclusion that a patient can't work is not enough. Social Security says, "We are responsible for making the determination or decision about whether [the claimant meets] the statutory definition of disability ... A statement by a medical source that you are 'disabled' or 'unable to work' does not mean that we will determine that you are disabled."²¹ A patient's medical report to Social Security should include a medical history, clinical findings, laboratory findings, diagnoses, treatment prescribed (with prognosis) and a medical assessment (i.e., the restrictions

walking. This was present Oct. 1, 1989, and has gotten progressively worse, despite good compliance with medication. Mr. Doe tires easily, due to the stiffness and pain from the arthritis, and reports feeling it necessary to lie down for up to one hour at a time at least twice a day. This is not unusual for patients with this type and severity of arthritis.

"Because of the arthritis, which will continue to worsen with age despite treatment, I would restrict Mr. Doe to not lifting more than five pounds, walking no more than five minutes every hour, standing no more than 10 minutes every hour and would caution him to change positions frequently and as needed. He will be unable to climb, bend, stoop and do fine manipulation and will be able to squat only with difficulty (and may require assistance to straighten up). He needs to lie down periodically during the day, and I have advised him to do so when necessary to relieve the pain. He is never pain-free and experiences more severe pain during hot

weather, cold weather and during times of temperature changes.

"Mr. Doe is a candidate for hip replacement surgery on the right side at some point in the future, although I have advised him to delay this surgery as long as possible. I would be hard pressed to imagine that Mr. Doe could work at any kind of a job. He has significant difficulty with daily living activities and, even on his best days, is substantially impaired.

"I have reviewed the Social Security Listings for arthritis, 1.03 and 1.04. Based on the foregoing, Mr. Doe meets Listing 1.03A, due to the severity of the arthritis of the right hip (both sides are severe but the right more so). There is gross anatomical deformity, along with significant bony destruction. The marked difficulty in walking is described above. I believe all elements required for 1.03A are present. At a minimum, the severity of the arthritis equals that described in 1.03A. I think 1.03A has been met since I first saw Mr. Doe."

The first example is not going

to help Mr. Doe. The second goes a long way toward making Mr. Doe's claim successful.

Conclusion

Some patients might want to consider hiring an attorney to help them with their disability claims. Many claimants with very good claims have been denied benefits because they did not understand the disability process. Most attorneys who work on Social Security cases do so on a contingent fee, which means that claimants pay the attorney only if the claim is successful. About 36% of disability claimants without an attorney get benefits. More than 60% of represented claimants get benefits.²³ □

Correspondence and reprints:
Steven Robison, Montgomery, Elsner
& Pardieck, P.O. Box 647, 308 W.
Second St., Seymour, IN 47274.

*For a list of references cited in
this article, write* INDIANA MEDICINE,
322 Canal Walk, Indianapolis, IN
46202-3252.

Doctor prescribes band aid for stress

Tina Sims
Managing Editor

Thomas Kintanar, M.D., feels as comfortable on a stage in a smoke-filled bar as he does in the sterile environment of the operating room – and no wonder. In either situation, he is doing what makes him happy.

Dr. Kintanar has a full-time family medicine practice in Fort Wayne, where he grew up. His practice and his family are the priorities in his life, but his music follows closely behind. Dr. Kintanar plays the keyboard and guitar and sings in Not My Kids, which performs in Fort Wayne area clubs and at private parties and wedding receptions. He is one of the original members of the band, formed six years ago.

Pop and rock songs from the 1960s to the present are in the band's repertoire, which numbers about 150 songs including those of The Allman Brothers, Aerosmith, The Doors, Billy Idol, J. Geils Band, Ted Nugent, Rush, Bob Seger and The Rolling Stones. Rock music is Dr. Kintanar's "first love," and the band's selections are heavily weighted in that category. "We do a lot of Led Zepelin, Journey and Nirvana. Some of it's very youthful, head-banging stuff," Dr. Kintanar says.

Judging from the band's popularity, there's a demand for such "head-banging stuff." At a late summer wedding reception, the bridegroom's father handed the band a generous tip to play for two additional hours because the guests weren't ready to quit dancing. (The neighbors appar-

ently weren't as impressed; the police made two runs to the reception to ask the band to keep the noise down.) The band also was voted best band for two consecutive years in the "Best of Allen County" contest sponsored by the *Fort Wayne Journal Gazette*.

The band already is booking engagements well into 1993, and its schedule is always full three months in advance. Dr. Kintanar isn't hesitant about touting the band's talent. "These guys are second to none," he says.

Dr. Kintanar never knows when his medical talents will be needed during their performance. When a guest once collapsed at a wedding reception where the

band was entertaining, Dr. Kintanar, who had just completed a shift in the hospital emergency department, rushed to his aid. Upon finding that the man was not breathing and had no pulse, Dr. Kintanar immediately began mouth-to-mouth resuscitation and asked a fellow band member to bring his medical bag. By the time the paramedics arrived, Dr. Kintanar had revived the man, who was taken to the hospital, where he recovered. His medical care completed, Dr. Kintanar and the other band members continued playing, and the wedding festivities resumed.

When mothers-to-be go into labor, they know that Dr. Kintanar will be there to deliver their baby, even if he is in the middle of the band's latest song. The show may go on, but Dr. Kintanar heads for the exit when a patient in labor awaits. He rejoins the band once he's delivered the baby.

There have been some eventful engagements, such as the night he was singing and watched through the club's front window as his illegally parked car was being towed away. Helpless to stop the auto's removal, he shared his plight with the audience by changing the lyrics of the song. He was singing to "There goes my car."

Dr. Kintanar finds the "ambiance" of a club exciting. "The smoke drives you crazy," he says "but when someone comes up and says 'you're fantastic,' it's worth it."

Although some patients are surprised to hear of his musical moonlighting, most are generally

Thomas Kintanar, M.D.

I like being a family physician because: Patient contact and feedback is a wonderful source of energy and enlightenment. There's a sense of gratification that you can never place a price on. I'm grateful for the God-given opportunity to be a physician, especially a family physician.

If I weren't a physician, I would be: Doing something which would be involved in patient care as well as continuing my musical involvement.

I relieve stress by: Playing the piano, guitar or basketball. □

accepting. "I've been really blessed to have a lot of understanding patients," he says. He does recall one elderly woman who refused to see him after she learned he played in a rock band.

Dr. Kintanar earned spending money during college by playing in bands. After he had set up his medical practice in Fort Wayne, a friend who owned a bar kept urging him to consider playing there. Dr. Kintanar finally agreed, and the gig extended to every Thursday night for two and a half years.

In the early days of Not My

Kids, some band members were concerned about Dr. Kintanar's commitment to the group because he had made it clear that his medical practice and his family came first. But he didn't want to stop playing, and the band didn't want to lose a valuable member. So some guidelines were established, and "now everyone is happy," Dr. Kintanar says.

One of the primary rules was that "egos don't supersede the importance of the band," explains Dr. Kintanar. A second keyboard player was hired so Dr. Kintanar wouldn't have to accompany the

band to out-of-town engagements, to such places as Angola and Decatur and nearby towns in Ohio. Members agreed that they would have to arrange rehearsals and performances around each other's work schedules. They also concurred that, although they were being paid, fun – after all – was why they were together in the first place.

The fun includes the weekly Wednesday rehearsals, when they gather in the loft of Dr. Kintanar's house. To avoid giving their audiences stale material, Dr. Kintanar says they try not to book more than two performances a month in the same lounge since their schedules permit them only enough time to learn one or two new songs each week.

Dr. Kintanar has written some original material, including a song that was on a locally produced album of Fort Wayne talent. Someday he hopes to produce his own record.

When he is not seeing patients or jamming with the band, Dr. Kintanar likes to spend time with his wife, Candace, and 3-year-old daughter, Taryn. Time with his wife is precious now, however, since she is a fourth-year medical student at Michigan State University, a two-hour drive from Fort Wayne. When she can't spare the time to come home on weekends, the family often meets halfway. Mrs. Kintanar hopes to enter a residency program in Fort Wayne after graduation.

Dr. Kintanar is active in the Indiana State Medical Association, serving as a delegate from the 12th District. He also is a 12th District delegate to the Indiana Academy of Family Physicians. □

Dr. Kintanar rehearses new material with the other members of Not My Kids during weekly Wednesday night sessions.



Intraoperative ultrasound of hepatic tumors

Regina R. Boggs
Dale A. Rouch, M.D.
Gonzalo T. Chua, M.D.
Indianapolis

Intraoperative ultrasound (IOUS) is a relatively new technique for imaging the liver. Detecting hepatic tumors, visualizing the vasculature of the liver and differentiating benign from malig-

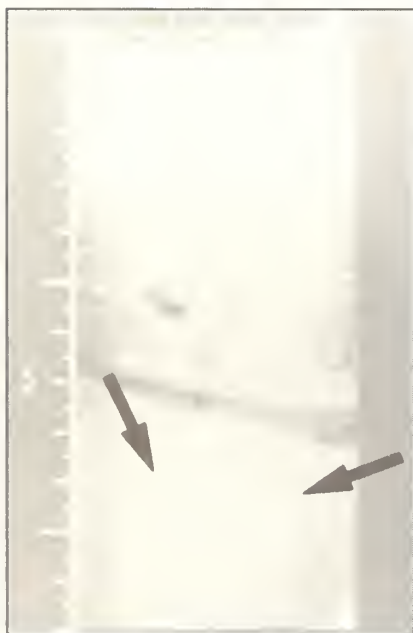


Figure 1: Intraoperative ultrasound indicated a 4-centimeter echogenic mass just posterior to the portal vein. The lesion was detected by CT but missed by repeated palpation. Biopsy diagnosis was cavernous hemangioma.

Abstract

Intraoperative ultrasound (IOUS) scanning of liver masses was compared with those of preoperative computed tomography (CT) and intraoperative palpation. Between March 1989 and May 1991, 24 patients underwent 25 IOUS procedures during laparotomy. Intraoperative ultrasound provided more information than the other modalities in 10 patients (40%) and affected operative management in eight patients (32%). It was concluded that IOUS, when used in conjunction with CT and palpation, is an important technique in the surgical management of patients with hepatic neoplasms.

nant lesions have been reported as important aspects of the procedure.¹⁻³ IOUS has been more effective than computed tomography (CT) and palpation for surgical management of patients with hepatic cancer.^{4,5}

Initially developed in Japan, where the rate of hepatocellular carcinoma is much higher than in the West, IOUS does not expose the patient to radiation and can be repeated throughout the surgery. This procedure is becoming routinely used in hepatic resections.

The purpose of this study was to quantify and compare the results of IOUS with preoperative CT scanning and intraoperative palpation for detection of primary and metastatic hepatic tumors.

Materials and methods

Between March 1989 and May 1991, 25 IOUS procedures were performed on 24 patients. Each underwent CT preoperatively and

palpation intraoperatively. There were 15 women and nine men, with an age range of 30 to 74 years and an average age of 59.8 years. Of these patients, 13 had colorectal metastases, five had other metastases (breast, ovarian, gastric, malignant melanoma, occult), five had primary hepatocellular carcinoma, and one had a benign cavernous hemangioma. All diagnoses were confirmed by fine needle biopsy.

IOUS was performed using an Acuson 128 (Acuson Corporation, Ocean View, Calif.) ultrasound machine with either a 5.0-MHz linear or 5.0-MHz sector array transducer. A disposable plastic sheath covered the transducer, and warm saline inside the peritoneal cavity acted as an acoustic interface. Permanent films were taken from the real-time images. An experienced radiologist and a surgeon were present for the procedure, which required approxi-

mately 10 minutes to perform.

Results

During 25 procedures, IOUS detected more tumors than preoperative CT scanning in six cases (24%), than palpation in one case (4%) and than both in one case (4%). In one patient, IOUS revealed that the lesion detected by CT but not palpation was a benign cavernous hemangioma (Figure 1). IOUS gave a false-positive result in one case (4%), CT gave false-positive results in two cases (8%), and both did in one case (4%). In one patient, all three methods, IOUS, CT and palpation, detected only two of the three nodules present, so each technique had one false-negative (4%) reading. Overall, IOUS provided more information than CT, palpation or both in 10 cases (40%).

IOUS visualized an additional area of liver involvement than preoperative CT (Figures 2 and 3),

which led to a larger resection in six patients (24%). Three patients were not resected: one because the metastatic disease as shown by IOUS was too aggressive; one because the lesion was accurately detected as being in the peritoneum by IOUS; and one because the area interpreted as having metastatic involvement was determined at biopsy to be normal liver tissue that had undergone fatty metamorphosis (Figure 4). In addition to the three patients who were not resected, three underwent a trisegmentectomy, nine received a lobectomy, six had a segmentectomy, and four patients underwent a wedge resection. Overall IOUS altered planned surgical management in eight cases (32%).

Discussion

The purpose of this study was to assess the effectiveness of IOUS in the surgical treatment of patients with primary and metastatic liver

disease. Several authors have reported benefits similar to those shown at this institution. Bismuth et al found that IOUS provided additional information to that obtained from preoperative investigations in 26 of 77 cases (33%), which modified intended surgical procedure in 21 cases (27%).⁶ Clarke's group showed that IOUS caused the operative plan to be changed in one-third of patients.⁷ Parker et al reported IOUS affected the operative management in 22 of 45 operative episodes (49%).⁸

In this study, palpation was taken as the standard of reference for the presence of liver lesions, except when CT, IOUS and, in some cases, inspection showed a tumor was present. Because there were two cases when IOUS was more accurate than palpation, it is important to consider the limitations of this standard of reference.

Each of the three techniques, CT, IOUS and palpation, was sub-

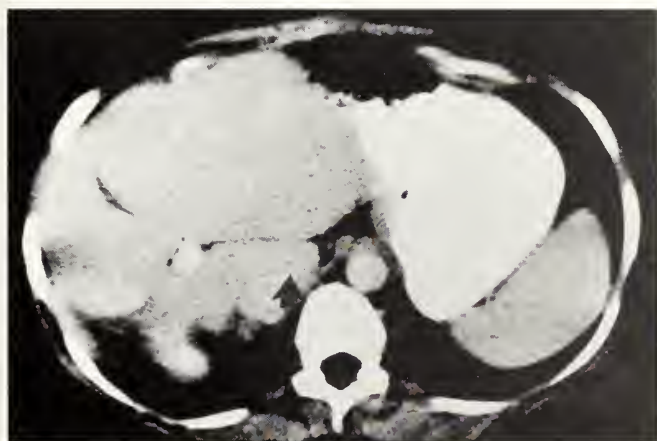


Figure 2: Pre-operative CT scan did not reveal any abnormality in the caudate lobe in a patient who had recent neoplasm in the right lobe.



Figure 3: Intraoperative ultrasound revealed a small tumor at the tip of caudal lobe.

Figure 4: Focal abnormality in caudal lobe in intraoperative ultrasound was found to be fatty metamorphosis.



ject to variability of effectiveness, but together they render a great deal of accurate information. While IOUS has a blind zone of the first 0.5-1.0 cm of the parenchyma,⁹ palpation usually detects lesions in this area. CT and IOUS each had false-positive results when artifacts were interpreted as tumors, but one of the other modalities usually compensated for the error. However, in one case, all three techniques detected two lesions yet missed a third, which was found only at biopsy.

In conclusion, IOUS was better than CT, palpation or both in 40% of these patients. Its results affected operative management in 32% of the cases. With IOUS's

ability to detect liver tumors, visualize hepatic vasculature and occasionally differentiate benign from malignant lesions, this procedure should be used routinely in the surgical management of patients with hepatic tumors. Based upon our findings and those of other groups, IOUS should be used at laparotomy for all patients with hepatic tumors, especially those suspected to be malignant. □

Ms. Boggs is research assistant, Dr. Rouch is director of liver transplantation/hepatobiliary surgery, and Dr. Chua is director of radiology education at Methodist Hospital of Indiana in Indianapolis.

Correspondence and reprints: Gonzalo T. Chua, M.D., Department of Radiology, Methodist Hospital of Indiana, 1701 N. Senate Blvd, P.O. Box 1367, Indianapolis, IN 46206.

References

1. Nagasue N, Suehiro S, Yukaya H: Intraoperative ultrasonography in the surgical treatment of hepatic tumors. *Acta Chir Scand*, 150:311-316, 1984.
2. Gozzetti G, Mazziotti A, Bolondi L, Cavallari A, Grigioni W, et al: Intraoperative ultrasonography in surgery for liver tumors. *Surgery*, 99:523-529, 1986.
3. Traynor O, Castaing D, Bismuth H: Preoperative ultrasonography in the surgery of hepatic tumors. *Br J Surg*, 75:197-202, 1988.
4. Castaing D, Emond J, Bismuth H, Kunstlinger F: Utility of operative ultrasound in the surgical management of liver tumors. *Ann Surg*, 204:600-605, 1986.
5. Rifkin M, Rosato F, Branch M, Foster J, Yang S, Barbot D, Marks G: Intraoperative ultrasound of the liver: An important adjunctive tool for decision making in the operating room. *Ann Surg*, 205:466-472, 1987.
6. Bismuth H, Castaing D, Garden J: The use of operative ultrasound in surgery of primary liver tumors. *World J Surg*, 11:610-614, 1987.
7. Clarke M, Kane R, Steele G, Hamilton E, Ravikumar T, Onik G, Clouse M: Prospective comparison of preoperative imaging and intraoperative ultrasonography in the detection of liver tumors. *Surgery*, 106:849-855, 1989.
8. Parker G, Lawrence W, Horsley S, Neifeld J, Cook D, et al: Intraoperative ultrasound of the liver affects operative decision making. *Ann Surg*, 209:569-577, 1989.
9. Castaing D, Kunstlinger F, Habib N, Bismuth H: Intraoperative ultrasonography study of the liver: Methods and anatomic results. *Am J Surg*, 149:676-682, 1985.

RBRVS

MFS

E/M

CF

AHPB

CHAOS

CPT

GPCI

RVU

HCEA

GAF

serenity.

Our accounts receivable management program includes comprehensive service bureau billing, expert profile review and coding assistance, physician reports, and regulatory updates.

Isn't that just what you'd expect from the medical billing expert? Call us today...
you can't afford not to.

 *Medical Accounts Group*
INCORPORATED

3901 North Meridian Street • Suite 200
Indianapolis, IN 46208
IN (317) 923-3046 • USA (800) 527-6244

■ scientific commentary

The Bethesda System and patient management strategies

Robin A. Helmuth, M.D.
Ann T. Moriarty, M.D.
G.R. Schwenk Jr., M.D.
Indianapolis

There is little question that the gynecologic smear (Pap smear) is largely responsible for the decrease in the number of deaths due to cervical cancer in the United States over the last 30 years. During this time, multiple systems used for interpreting and reporting these smears have evolved, including the Papanicolaou classification, the cervical intraepithelial neoplasia (CIN) system and a descriptive system. The Bethesda System was introduced in 1990 and is used by approximately 80% of clinical laboratories performing gynecologic smears. A revision of the Bethesda System guidelines was issued recently. Its final impact on the protocol and management guidelines discussed in this article is uncertain.

Although pathologists deal daily with gynecologic smears and their interpretations, the Bethesda System and its integration with the other more traditional classification systems can be confusing. Discussions with physicians and other health care providers directly associated with patients confirm this impression. Therefore, we think it would be valuable to publish a simple, easily visualized chart cross-referencing the Papanicolaou classification, the cervical intraepithelial neoplasia system, a descriptive system and the Bethesda System (Table 1).

The advent of the Bethesda System mandated additional changes, including a statement of adequacy, a descriptive diagnosis and a recommendation for treat-

ment or follow-up. Although Hansell and Rogers¹ successfully guide the provider when a smear contains condylomatous changes, dysplasia or carcinoma, little mention is made of a management strategy for other conditions such as: "inadequate or suboptimal"; "atypical squamous cells of undetermined significance"; or "reactive and reparative changes with ..."

In our experience, these "other" conditions create the most confusion for providers, especially in clinic-type settings where there is an effort to streamline patients and their follow-up care. Although each patient presents a unique situation, we have found that a protocol for gynecologic smear follow-up (Table 2) is extremely helpful in the overall management of patients with squamous lesions.

A specific example of this is a report of "inadequate or suboptimal." If this is due to a lack of endocervical cells, and the patient has a cervix, the smears should be repeated. Historically, repeat smears were performed as soon as it was feasible to re-examine the patient. Because the reparative process after any "injury," including simple gynecologic sampling, may take two to three months to completely resolve, we now recommend delaying repeat smears for three to six months. This delay avoids interpreting a smear with reactive and reparative changes and helps reduce the uncertainty of how to act upon such a pathologic report.

Another example is a report of "inadequate or suboptimal due to air-drying artifact." The artifactual changes occasionally will result in under- or over-classification of a lesion as benign or dysplastic. The smears should be

repeated with immediate fixation, three to six months later. When a report of "inadequate or suboptimal" is rendered, definitive follow-up action should be taken to obtain a smear satisfactory for interpretation.

"Atypical squamous cells of undetermined significance" is not an unusual description in a report. By definition, there is no cause for the atypia on the slides. The smear should be repeated in three to six months. If the atypia persists, physicians should perform a colposcopy and, when indicated, a biopsy.

"Reactive and reparative" changes can be due to a variety of processes. Some of these are noted in Table 2. If appropriate treatment is provided and the repeat smears do not resolve, physicians should consider other causes and perhaps the need for a colposcopy, depending on the situation. This should minimize over-zealousness to perform procedures and biopsies on patients with simple reparative changes and reduce the chance of overlooking a patient with an unresolving/progressive process.

"Low-grade" and "high-grade" squamous intraepithelial lesions also are noted. While the descriptive systems distinguish between condylomatous atypia and mild dysplasia, the Bethesda System groups them as a "low-grade intraepithelial lesion." We recommend colposcopy and/or biopsy to ensure that additional studies are performed. Either of these may be useful to clinicians in evaluating the extent of the lesion(s).

By understanding the Bethesda System used for reporting gynecologic smears and the protocol for follow-up, the chances of overlooking a signifi-

Table 1

Cervical/vaginal cytologic reporting systems

<u>Class</u> *	<u>Description</u>	<u>CIN</u> ⁺	<u>Bethesda</u> ⁰
—	—	—	Inadequate or suboptimal specimen. Recommend repeating smears in 3-6 months.
I	Normal	—	Satisfactory for interpretation. Within normal limits. Recommend repeating smears annually.
II	Inflammation	—	Satisfactory for interpretation. Reactive or reparative changes in association with (specify infectious agent). Recommend treating for specified infection and repeating smears annually.
II	Repair	—	Satisfactory for interpretation. Reactive and reparative changes. Recommend repeating smears annually.
—	—	—	Satisfactory for interpretation. Atypical squamous cells of undetermined significance. Recommend repeating smears in 3-6 months.
III	Condyloma	—	Satisfactory for interpretation. Low-grade squamous intraepithelial lesion (HPV-associated changes). Recommend colposcopy and/or biopsy if clinically indicated.
III	Mild dysplasia	I	Satisfactory for interpretation. Low-grade squamous intraepithelial lesion (mild dysplasia). Recommend colposcopy and/or biopsy if clinically indicated.
III	Moderate dysplasia	II	Satisfactory for interpretation. High-grade squamous intraepithelial lesion (moderate dysplasia). Recommend colposcopy and biopsy.
III	Severe dysplasia	III	Satisfactory for interpretation. High-grade squamous intraepithelial lesion (severe dysplasia). Recommend colposcopy and biopsy.
III	Carcinoma in situ	III	Satisfactory for interpretation. High-grade squamous intraepithelial lesion (carcinoma in situ). Recommend colposcopy and biopsy.
IV/V	Squamous cell carcinoma	—	Satisfactory for interpretation. Squamous cell carcinoma. Recommend colposcopy and biopsy.

* = Papanicolaou Class System

+ = Cervical Intraepithelial Neoplasia System

⁰ = Bethesda Conference System

Table 2

Suggested guidelines for gynecologic (Pap) smear follow-up

<u>Bethesda description</u>	<u>Questions/information</u>		<u>Recommended action</u>
"Inadequate or suboptimal due to lack of endocervical cells."	Does patient have a cervix?	YES NO	Repeat in 3-6 mos. Repeat smears annually (amend report to indicate above information).
"Inadequate or suboptimal due to abundant erythrocytes."	Was patient menstruating at time of sample? (1-7 days after start of LMP)	YES NO	Repeat during nonmenstrual phase Exclude other causes of bleeding (infection, atrophy, neoplasm).
"Inadequate or suboptimal due to severe inflammation."	Is inflammatory agent specified?	YES NO	Treat for infection and repeat smears 3-6 mos. post-treatment. Perform additional studies to confirm source of infection; treat and repeat smears 3-6 mos. post-treatment.
"Inadequate or suboptimal due to air-drying artifact."			Repeat in 3-6 mos. with immediate fixation. (If this is a routine comment, consider revising procedure or methods for obtaining and initially handling the specimen.)
"Satisfactory for interpretation. Atypical squamous cells of undetermined significance."			Repeat in 3-6 mos. (If atypical cells still present, recommend colposcopy).
"Satisfactory for interpretation. Reactive and reparative changes."	With "atrophy"		Topical estrogen trial and repeat smears in 3-6 mos.
"Satisfactory for interpretation. Reactive and reparative changes."	With specified infectious agent		Treat for infection and repeat smears annually.
	With "inflammation"		Perform additional studies to identify possible cause of inflammation; if no source identified, repeat smears in 3-6 mos.
"Satisfactory for interpretation. Low-grade squamous intra-epithelial lesion"(condylomatous atypia or mild dysplasia).			Colposcopy and/or biopsy.
"Satisfactory for interpretation. High-grade squamous intra-epithelial lesion"(moderate dysplasia, severe dysplasia or carcinoma in situ).			Colposcopy with biopsy.
"Satisfactory for interpretation. Invasive carcinoma."			Colposcopy with biopsy.

NOTE: These are only guidelines and are not strict rules. Each patient and clinical situation is unique; therefore, treatment should be individualized to maximize the benefits for the patient.

■ scientific commentary

cant finding or overreacting to an insignificant finding will be minimized. □

The authors are with the Department of Pathology and Laboratory Medicine at Methodist Hospital of Indiana in Indianapolis.

Correspondence: Robin A. Helmuth, M.D., Department of Pathology and Laboratory Medicine, Methodist Hospital of Indiana, Inc., 1701 N. Senate Blvd., P.O. Box 1367, Indianapolis, IN 46206.

References

1. Hansell RS, Rogers RE: The man-

agement and treatment of an abnormal Pap smear. *Indiana Med*, 83:468-473, 1990.

2. Solomon D: The 1988 Bethesda System for reporting cervical/vaginal cytologic diagnoses: Developed and approved at the National Cancer Institute Workshop in Bethesda, Md., Dec. 12-13, 1988. *Human Pathol*, 21:704-708, 1990.

3. College of American Pathologists Summary Report, 1991.



SAFE
EFFECTIVE
CONVENIENT
ECONOMICAL

Mono-Gesic[®] Tablets
(750mg Salsalate)

A well tolerated
Salicylate Therapy



C[®] CENTRAL PHARMACEUTICALS, INC.
SEYMOUR, INDIANA 47274 USA
Quality Pharmaceuticals Since 1904

■ auxiliary report

Trudy Urgena
ISMA Auxiliary President

The ISMA Auxiliary Long-Range Planning Committee brainstormed during a summer retreat to set immediate and future goals. The committee recommended the following:

1) Change the name Indiana State Medical Association Auxiliary to Indiana State Medical Association Alliance to conform to the national organization's name change.

2) Employ a strategic planner to develop an action plan to meet the challenges of the 21st century.

3) Emphasize "teamwork" between the auxiliary and medical society at all times on both the state and county levels.

4) Co-sponsor with the ISMA a resolution to be presented at the 1992 ISMA House of Delegates requesting that county medical societies and auxiliaries work together to promote programs to fight family violence.

Need for strategic planning

The ISMA Auxiliary is in the midst of a strategic planning process to help it become more responsive to members' needs. These needs were identified through a survey and focus group sessions.

The survey was sent to all current and eligible members to collect information regarding: 1) perceived needs that the ISMA Auxiliary could address; 2) current perceptions of the ISMA Auxiliary; and 3) reasons for joining, not joining or dropping out of the ISMA Auxiliary.

The focus groups, which were open to all active and eligible members, met in Indianapolis, Culver and Evansville to establish

priorities to be addressed by both the state and county auxiliaries.

Since grass-roots participation is vital to the success of our planning, the focus group sessions provided members with an opportunity to be involved in the planning process. Members were able to "buy-in" as partners in the organizational changes.

This strategic planning process allows the state and county auxiliaries to decide their future courses and determine what needs to be done now to get there. By identifying and analyzing current programs, better action plans can be developed and groundwork can be laid to ensure continuity through an ongoing team effort.

Family violence resolution

To promote a closer working relationship between the ISMA and its auxiliary, the auxiliary requested, and the ISMA Board of Trustees approved, a joint resolution concerning family violence to

be introduced at the 1992 ISMA House of Delegates.

John Knot, M.D., AMA delegate and ISMA past president, introduced the resolution.

The ISMA and its auxiliary will encourage physicians and their spouses to participate in the AMA National Campaign Against Family Violence and work toward promoting a safer family environment for Indiana residents.

Future events

Feb. 17, 1993 – Legislative Event Day, Embassy Suites, downtown Indianapolis. Topics will include "How to Organize for Legislative Effectiveness," "How to Lobby Your Legislator," "Legislative Update," and "How to Plan & Implement a County Legislative Mini-Internship Program."

April 21-23, 1993 – ISMA Auxiliary Annual Convention, Days Inn Recreational Atrium, Marion, Ind. □

Auxiliary celebrates its 65th anniversary

The ISMA Auxiliary (ISMA-A) celebrated its 65th anniversary in September with a medical family seminar and celebration luncheon. Program topics included "Children in Affluent Families," "Sex, Passion & Intimacy!" and "Stress and Impairment in the Medical Family." Members learned about relationship dynamics, intimacy in the medical marriage and the significance of medical family dynamics.

The ISMA-A was founded in 1927 under the presidency of Mrs. Frank Cregor of Indianapolis. Three years earlier, her husband, Dr. Frank W. Cregor, ISMA president, read that the AMA had an auxiliary composed of wives of AMA members. He suggested that she attend the AMA Auxiliary meeting held during the AMA convention. She did and was Indiana's only representative. She returned to Indiana with a vision to create an auxiliary.

Mrs. Cregor helped form the auxiliary to the Indianapolis Medical Society in the fall of 1926, making it the first county medical auxiliary in Indiana. A year later, on Sept. 8, 1927, the ISMA-A was organized when other doctors' wives from five or six other counties joined with the Indianapolis Medical Auxiliary to form a state organization with constituent auxiliaries.

Building on the accomplishments of the past 65 years, the state auxiliary currently is involved with strategic planning to address the issues of the '90s and the challenges of the 21st century. □

OFFICERS

President — William H. Beeson, Indianapolis
 Pres.-elect — William C. Van Ness II, Summitville
 Immediate Past Pres — C. Dyke Egnatz, Schererville
 Executive Director — Richard R. King, Indianapolis
 Treasurer — John A. Bizal, Evansville
 Asst. Treasurer — Timothy Brown, Crawfordsville
 Speaker — William E. Cooper, Columbus
 Vice Speaker — Peter Winters, Indianapolis

EXECUTIVE COMMITTEE

*William H. Beeson, Indianapolis
 William C. Van Ness II, Summitville
 C. Dyke Egnatz, Schererville
 Jerome Melchior, Vincennes
 John A. Bizal, Evansville
 Timothy Brown, Crawfordsville
 Alfred Cox, South Bend
 John Thomas, Fort Wayne
 William E. Cooper, Columbus
 Peter Winters, Indianapolis

TRUSTEES (Terms end in October)

District

1 — Bruce Romick, Evansville (1995)
 *2 — Jerome E. Melchior, Vincennes (1993)
 3 — Gordon L. Gutmann, Jeffersonville (1994)
 4 — Arthur C. Jay, Lawrenceburg (1995)
 5 — Fred E. Haggerty, Greencastle (1993)
 6 — Ray Haas, Greenfield (1994)
 7 — Ronald Blankenbaker, Indianapolis (1995)
 7 — John M. Records, Franklin (1993)
 7 — Bernard Emkes, Indianapolis (1994)
 8 — John V. Osborne, Muncie (1993)
 9 — Stephen Tharp, Frankfort (1994)
 10 — Frank Sturdevant, Valparaiso (1995)
 11 — Jack W. Higgins, Kokomo (1993)
 12 — John R. Thomas, Fort Wayne (1994)
 13 — Alfred C. Cox, South Bend (1995)
 RMS — Clint E. Myers, Indianapolis (1993)
 MSS — Paul Forman, Indianapolis (1993)
 *Chairman

ALTERNATE TRUSTEES (Terms end in October)

District

1 — Barney R. Maynard, Evansville (1994)
 2 — James P. Beck, Washington (1995)
 3 — John H. Seward, Bedford (1995)
 4 — Lawrence R. Bailey Jr., Aurora (1994)

5 — Roland M. Kohr, Terre Haute (1994)
 6 — Howard C. Deutsch, Richmond (1995)
 7 — Frank Johnson, Indianapolis (1994)
 7 — Paula Hall, Mooresville (1995)
 7 — Ronald Stegemoller, Danville (1993)
 8 — Susan K. Pyle, Union City (1994)
 9 — Daniel Berner, Lafayette (1995)
 10 — Tom Brubaker, Munster (1994)
 11 — Laurence K. Musselman, Marion (1995)
 12 — Joseph Manthey, Bluffton (1995)
 13 — Richard J. Houck, Michigan City (1994)
 RMS — Carla Brumbaugh, Indianapolis (1993)
 MSS — Scott Hollingsworth, Indianapolis (1993)

AMA DELEGATES (Terms end Dec. 31)

Marvin E. Priddy, Fort Wayne (1993)
 John D. MacDougall, Beech Grove (1993)
 Herbert Khalouf, Marion (1993)
 John A. Knotte, Lafayette (1992)
 Alvin J. Haley, Carmel (1992)
 George T. Lukemeyer, Indianapolis (1992)

AMA ALTERNATE DELEGATES (Terms end Dec. 31)

Michael O. Mellinger, LaGrange (1993)
 George Rawls, Indianapolis (1993)
 Shirley Thompson Khalouf, Marion (1992)
 Max N. Hoffman, Covington (1992)
 Edward L. Langston, Indianapolis (1992)

DISTRICT OFFICERS AND MEETINGS

1 — Pres: Gregory Hindahl, Jasper
 Secy: Mariellen Dentino, Evansville
 Annual Meeting: May 20, 1993
 2 — Pres: Bill Vaughn, Vincennes
 Secy: Mike Kelly, Vincennes
 Annual Meeting: May 13, 1993
 3 — Pres: John Norton, Corydon
 Secy: Rashidul Islam, New Salisbury
 Annual Meeting: May 19, 1993
 4 — Pres: Manuel Garcia, Batesville
 Secy: David Welsh, Batesville
 Annual Meeting: May 5, 1993
 5 — Pres: Paul Houston, Brazil
 Secy: Rahim Farid, Brazil
 Annual Meeting: May 27, 1993
 6 — Pres: William Toedebusch, Richmond
 Secy: Helen Steussy, New Castle
 Annual Meeting: May 12, 1993
 7 — Pres: Ronald Stegemoller, Danville

Secy: Craig Moorman, Franklin
 Annual Meeting: to be announced
 8 — Pres: Gordon M. Hughes, Muncie
 Secy: Gerard T. Costello, Muncie
 Annual Meeting: June 2, 1993
 9 — Pres: Thomas A. Mabel, Noblesville
 Secy: Stephen D. Tharp, Frankfort
 Annual Meeting: to be announced
 10 — Pres: Filemon P. Lopez, Dyer
 Secy: Barron M. Palmer, Hammond
 Annual Meeting: Sept. 15, 1993
 11 — Pres: Regino Urgena, Marion
 Secy: Frederick C. Poehler, La Fontaine
 Annual Meeting: Sept. 15, 1993
 12 — Pres: William Aeschliman, Fort Wayne
 Secy: Joseph Manthey, Bluffton
 Annual Meeting: Sept. 16, 1993
 13 — Pres: Michael Deery, Culver
 Secy: John W. Schurz, South Bend
 Annual Meeting: Sept. 8, 1993

COMMISSION CHAIRMEN

Constitution and Bylaws

Helen E. Czenkusch, Indianapolis
Legislation

Eugene G. Roach, Anderson
Physician Assistance

Robert Nelson, South Bend
Medical Services

Dallas E. Coate, Lebanon

Medical Education

James E. Carter, Indianapolis

Sports Medicine

Ronald G. Blankenbaker, Indianapolis

COMMITTEE CHAIRMEN

Medical Malpractice (Ad Hoc)

George T. Lukemeyer, Indianapolis

Grievance

Richard B. Schnute, Indianapolis

Indiana Medical Foundation

Frank B. Ramsey, Indianapolis

CHAIRMEN OF ISMA SPECIALTY SECTIONS

ALLERGY

Paul D. Isenberg, Indianapolis

ANESTHESIOLOGY

Stephen F. Dierdorf, Indianapolis

CUTANEOUS MEDICINE

Peter L. Winters, Indianapolis

DIRECTORS MEDICAL EDUCATION

Glenn Bingle, Indianapolis

EMERGENCY MEDICINE

Thomas C. Madden, Greenwood

FAMILY PRACTICE

John Haste, Argos

INTERNAL MEDICINE

Neil Irick, Indianapolis

MEDICAL DIRECTORS AND STAFF PHYSICIANS OF NURSING FACILITIES

Larry G. Cole, Yorktown

NEUROLOGICAL SURGERY

Marvin R. Bernard, Merrillville

NEUROLOGY

Charles A. Bonsett, Indianapolis

NUCLEAR MEDICINE

Mike Mullinix, Indianapolis

OBSTETRICS & GYNECOLOGY

Philip N. Eskew Jr., Carmel

OPHTHALMOLOGY

D. Dean Cofield, Bloomington

ORTHOPAEDIC SURGERY

James G. Buchholz, Fort Wayne

OTOLARYNGOLOGY, HEAD & NECK SURGERY

William F. Cooper, Columbus

PATHOLOGY & FORENSIC MEDICINE

Joyce Byllesby, Washington

PEDIATRICS

Charlene Graves, Indianapolis

PHYSICAL MEDICINE AND REHABILITATION

Robert Gregon, Indianapolis

PREVENTIVE MEDICINE AND PUBLIC HEALTH

Gary A. Babcock, Chesterton

PSYCHIATRY

Patricia Sharpley, Indianapolis

RADIOLOGY

Edward C. Wheeler, Carmel

SURGERY

Bud H. McDougal, Indianapolis

UROLOGY

Rodney A. Mannion, LaPorte

ISMA KEY STAFF

Richard R. King, Executive Director

Adele Lash, Director of Operations/Communications

Mike Abrams, Director of Marketing/Legislation

John Wilson, Director of Administration

Ronald Dyer, General Counsel

Susan Grant, Executive Assistant

Richard Ryan, Field Services (Northern)

Bob Sullivan, Field Services (Central)

Janna Kosinski, Field Services (Southern)

Barbara Walker, Practice Management Consultant

Tom Martens, Members Health Insurance

Tina Sims, INDIANA MEDICINE

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

Required by 39 U.S.C. 3685

1A. Title of Publication Indiana Medicine		1B. PUBLICATION NO. 0 7 4 6 8 2 8 8				2. Date of Filing Oct. 1, 1992	
3. Frequency of Issue Bimonthly		3A. No. of Issues Published Annually 6				3B. Annual Subscription Price \$15	
4. Complete Mailing Address of Known Office of Publication (Street, City, County, State and ZIP+4 Code) (Not printers) 322 Canal Walk, Indianapolis, Marion County, IN 46202-3252							
5. Complete Mailing Address of the Headquarters of General Business Offices of the Publisher (Not printer) 322 Canal Walk, Indianapolis, IN 46202-3252							
6. Full Names and Complete Mailing Address of Publisher, Editor, and Managing Editor (This item MUST NOT be blank) Publisher (Name and Complete Mailing Address) Indiana State Medical Association 322 Canal Walk, Indianapolis, IN 46202-3252 Editor (Name and Complete Mailing Address) None Managing Editor (Name and Complete Mailing Address) Tina Sims, 322 Canal Walk, Indianapolis, IN 46202-3252							
7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.) (Item must be completed.)							
Full Name		Complete Mailing Address					
Indiana State Medical Association		322 Canal Walk Indianapolis, IN 46202-3252					
Non-profit corporation							
No stockholders							
8. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages or Other Securities (If there are none, so state)							
Full Name		Complete Mailing Address					
None							
9. For Completion by Nonprofit Organizations Authorized to Mail at Special Rates (DMM Section 423.12 only) The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes (Check one)							
(1) <input checked="" type="checkbox"/> Has Not Changed During Preceding 12 Months		(2) <input type="checkbox"/> Has Changed During Preceding 12 Months		(If changed, publisher must submit explanation of change with this statement.)			
10. Extent and Nature of Circulation (See instructions on reverse side)		Average No. Copies Each Issue During Preceding 12 Months		Actual No. Copies of Single Issue Published Nearest to Filing Date			
A. Total No. Copies (Net Press Run)		6,993		7,070			
B. Paid and/or Requested Circulation							
1. Sales through dealers and carriers, street vendors and counter sales		0		0			
2. Mail Subscription (Paid and/or requested)		6,722		6,800			
C. Total Paid and/or Requested Circulation (Sum of 10B1 and 10B2)		6,722		6,800			
D. Free Distribution by Mail, Carrier or Other Means Samples, Complimentary, and Other Free Copies		174		177			
E. Total Distribution (Sum of C and D)		6,896		6,977			
F. Copies Not Distributed							
1. Office use, left over, unaccounted, spoiled after printing		97		93			
2. Return from News Agents		0		0			
G. TOTAL (Sum of E, F1 and 2—should equal net press run shown in A)		6,993		7,070			
11. I certify that the statements made by me above are correct and complete		Signature and Title of Editor, Publisher, Business Manager, or Owner Richard R. King Business Manager					

CARDIOLOGY - DIAGNOSTIC & INTERVENTIONAL



NASSER, SMITH AND PINKERTON CARDIOLOGY, INC.

William K. Nasser, M.D.

Michael L. Smith, M.D.

Cass A. Pinkerton, M.D.

James W. VanTassel, M.D.

Dennis K. Dickos, M.D.

John D. Slack, M.D.

Charles M. Orr, M.D.

Jane Howard, M.D.

James H. Adlam, M.D.

V. Michael Bournique, M.D.

Frank J. Green, M.D.

Nancy A. Branyas, M.D.

Charles P. Taliercio, M.D.

Bruce F. Waller, M.D.

Thomas F. Peters, M.D.

Lawrence E. Gering, M.D.

providing

Cardiology & Cardiac Catheterization

Transesophageal Echocardiography

Doppler & Echocardiography

Exercise Stress Testing

Coronary Angioplasty

Nuclear Cardiology

Pacemaker Surveillance

Holter Monitoring

Percutaneous Valvuloplasty

Electrophysiology Testing

Coronary Atherectomy

Myocardial Biopsy

Automatic Implantable

Cardioverter Defibrillator

Signal Averaged Electrocardiography

Nutrition Services

Cardiac Rehabilitation

Office: 317-871-6666

1-800-732-1482

1-800-CHD-PTCA

1-800-CAD-PTCA

FAX: 317-871-6019

With additional offices

located in:

Anderson • Brazil

Carmel • Kokomo

Marion • Terre Haute

Suite 400

St. Vincent Professional Building

8402 Harcourt Road

Indianapolis, Indiana 46260

THE HEART CENTER OF INDIANA

CARDIOLOGY

FORT WAYNE CARDIOLOGY

Basil C. Genetos, M.D.
Robert W. Godley, M.D.
Michael J. Mirro, M.D.
Kevin J. Kelly, M.D.
Fred Doloresco, M.D.
John F. Phillips, M.D.
Patrick J. Daley, M.D.
William W. Wilson, M.D.
James J. Heger, M.D.
Raymond E. Dusman, M.D.
Charles F. Presti, M.D.
Stephen E. Brown, M.D.
David D. Whang, M.D.

Practice Limited to Cardiology
(Physician's Referral Only)

Locations nearby:

1912 Carew Street
Fort Wayne, Indiana 46805
(219) 482-4865 (800) 637-6505 (IN)
(800) 334-4371 (MI & OH)

Lutheran Medical Park
7900 W. Jefferson Blvd.
Suite 202
Fort Wayne, Indiana 46804
(219) 432-5613

Caring for people is the first priority at Fort Wayne Cardiology. Since 1978, our team approach has served referring physicians and their patients with the latest in heart care treatment and technologies.

Fort Wayne Cardiology is a trusted and caring group of people, featuring 13 board certified/board eligible cardiologists, as well as a special staff of nurses, technologists and administrative assistants. Patients are able to receive comprehensive cardiac services which include: cardiac catheterization, coronary angioplasty and atherectomy, electrophysiology, valvuloplasty, nuclear cardiology, doppler and echo cardiography, exercise stress testing, holter monitoring, ECG event monitoring, permanent pacemaker implantation and surveillance, non-invasive peripheral vascular evaluation, peripheral angioplasty and atherectomy, myocardial biopsy, transesophageal echo, AICD insertion and surveillance, signal average EKG, tilt table and rehab therapy.

University trained, certified cardiologists; the best in diagnostic equipment; clinical research and specialization within the specialty, makes Fort Wayne Cardiology an excellent center for heart care.

Satellite Clinics:

Angola	Kendallville	Defiance, OH
Auburn	LaGrange	Hicksville, OH
Columbia City	Wabash	
Huntington	Warsaw	

CARDIOLOGY

A new era in heart care has begun...

Now open



Robert E. Swint, Sr., M.D.

Mark A. Jones, M.D.

David A. Kaminskas, M.D.

Gary A. Hambel, M.D.

Mary H. Heintz, M.D.

Ravi N. Bathina, M.D.

Gregory C. Tomlinson, M.D.

Brian T. Lew, M.D.

Peter C. Hanley, M.D.

Christopher Zee-Cheng, M.D.

Steven W. Orlow, M.D.

David A. Belvedere, M.D.

Mark S. Hazen, M.D.

7836 W. Jefferson Blvd.

Fort Wayne, IN 46804

(219) 432-2297

800 Broadway, Suite 204

Fort Wayne, IN 46802

(219) 422-2558

3217 Lake Ave.

Fort Wayne, IN 46805

(219) 422-2297

2510 Dupont Rd.

Fort Wayne, IN 46825

(219) 489-8280

1-800-777-2297

CARDIOLOGY

Indiana Heart Physicians, Inc.

a member of the
Indianapolis Regional Heart Center
at St. Francis

Indianapolis/Beech Grove Medical Center
112 North 17th Avenue, Suite 300

Office	317-783-8800
Appointment Scheduling	317-781-3615
Cardiac Testing Center	317-781-3636
Toll Free (Nationwide)	800-992-2081

Consulting Offices at:

Greenwood
Shelbyville
Martinsville

Indiana Heart Physicians at Columbus
3154 North National Road, Suite C

Office	812-379-2020
Toll Free (Indiana)	800-331-4765

Physicians

H. O. Hickman, Jr., M.D., FACC
Thomas M. Mueller, M.D., FACC
J. Douglas Graham III, M.D., FACC
Kathleen H. Flohr, M.D., Ph.D., FACC
Jeffrey L. Christie, M.D., FACC
Stephen H. Kliman, M.D., FACC
Thomas C. Passo, M.D., FACC
Emily A. Diltz, M.D., FACC
John E. Batchelder, M.D., FACC
Mark D. Cohen, M.D., FACC
William J. Berg, M.D.
Thomas D. Hughes, D.O.
George E. Revtyak, M.D., FACC
Jeffrey Mossler, M.D.
Irwin Labin, M.D., FACC

at Columbus

David J. Hamilton, M.D., FACC
Kevin C. Preuss, M.D., FACC

providing

Cardiology and Cardiac
Catheterization
Coronary Angioplasty
Coronary Atherectomy
Electrophysiology
Percutaneous Valvuloplasty
Nuclear Cardiology
Stress Echocardiography
Exercise Stress Testing
Holter Monitoring
ECG Event Monitoring
Permanent Pacemaker Implantation
Pacemaker Surveillance
Color Flow Doppler Echocardiography
Laser Angioplasty
Trans-Telephonic Pacemaker Analysis

Noninvasive Peripheral
Vascular Evaluation
Signal Average EKG
Myocardial Biopsy
Tilt Table Testing

CARDIOLOGY



Indianapolis Cardiology Associates, Inc.

Robert E. Edmands, M.D., F.A.C.C.

Samuel M. Hazlett III, M.D.

Don B. Ziperman, M.D., F.A.C.C.

Bradley A. Weinberg, M.D.

are pleased to announce the association of

Richard A. Hahn, M.D.

for the practice of cardiology.

- Cardiology & Cardiac Catheterization
- Coronary Angioplasty
- Laser Angioplasty
- Coronary Atherectomy
- Echocardiography
- Transesophageal Echocardiography
- Color Flow Imaging
- Nuclear Cardiology
- Stress Testing
- Holter Monitoring
- Pacemaker Surveillance
- Permanent Pacemaker Implantation
- Evaluation of Cardiac Risk Factors
- Cardiac Rehabilitation Program

East Location

1400 N. Ritter Avenue, Suite 585

Indianapolis, Indiana 46219

Office~(317) 355-1500

Referring Physician Line~(317) 355-1100

North Location

7250 Clearvista Drive, Suite 227

Indianapolis, Indiana 46256

Office~(317) 841-5385

Referring Physician Line~(317) 841-5386

CARDIOLOGY

THE HEART CENTER OF MARION



Prakash N. Joshi, M.D., F.A.C.C.
Diplomate, American Board of
Internal Medicine & Cardiovascular
Diseases

Subodh S. Gupte, M.D., F.A.C.C.
Diplomate, American Board of
Internal Medicine, Cardiovascular
Diseases and Advanced Achievement
in Internal Medicine

providing
Cardiology
Electrocardiogram
Exercise Stress Testing
Doppler &
Echocardiography
Stress
Echocardiography
Holter Monitoring

**703 Chapel Pike
Marion, Indiana 45952
Appointments: (317) 664-1201
Business Office: 1-800-345-2035
FAX: (317) 664-2866**

Nasser, Smith & Pinkerton Cardiology, Inc.

DOCTORS

These spaces are available.

**For rates, write or call
INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-4762.**

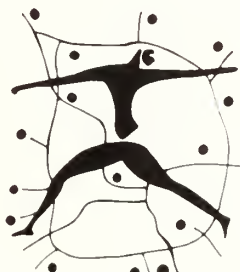
PLASTIC, RECONSTRUCTIVE & HAND SURGERY

One Call, Day or Night!

Our group is always available, 365 days a year, day or night; to see your patients in Indianapolis because there are times when your patient shouldn't have to wait.

ALSO SEEING PATIENTS
BY APPOINTMENT IN THESE
CENTRAL INDIANA CITIES:

BEECH GROVE
CRAWFORDSVILLE
DANVILLE
GREENCASTLE
GREENSBURG
KOKOMO
LEBANON
MOORESVILLE
SURGERY CENTER



SERVING 15 CENTRAL
INDIANA HOSPITALS

VISA, MASTERCARD ACCEPTED
FINANCING AVAILABLE

ZOLLMAN CENTER FOR PLASTIC & HAND SURGERY

7439 Woodland Drive, Indianapolis, IN 46278



Member, American Society
of Plastic and Reconstructive Surgeons

317-328-1100

1-800-332-3943

FAX: 317-328-6948

Wally Zollman M.D., F.A.C.S., Twatchai Yamcharern M.D., F.A.C.S., Richard S. Troiano M.D., F.A.C.S.

PLASTIC SURGERY

MERIDIAN PLASTIC SURGERY CENTER

For information on services
317/575-0110
or 800/352-7849
106th & Meridian Streets
Indianapolis



An Ambulatory Surgery Center
Exclusively for Cosmetic, Plastic
and Reconstructive Surgery

Board-Certified Physicians

- Stephen W. Perkins, MD, FACS
- William R. Nunery, MD, FACS
- Ronald T. Martin, MD
- A. Michael Sadove, MD, FACS
- Barbara K. Siwy, MD, FACS

Facial, Ophthalmic & General
Plastic Surgery • Anesthesiology
Licensed by the Indiana State
Board of Health • Medicare
Certified

PLASTIC SURGERY



AMERICAN SOCIETY OF
PLASTIC & RECONSTRUCTIVE
SURGEONS, INC.

John G. Pantzer Jr., M.D., F.A.C.S.
Diplomate, American Board
of Plastic Surgery

1801 North Senate Blvd., Suite 735
Indianapolis, Indiana 46202
317-929-5500

RADIOLOGY

SUPERB QUALITY DIAGNOSTIC RADIOLOGY AND RADIATION ONCOLOGY SERVICES ARE ONLY A TELEPHONE CALL AWAY...

Our mission is to provide caring, high quality, state-of-the-art imaging, interventional, and radiation oncological services to our patients, referring clinicians, and institutions. Call us today to discuss your unique requirements or to refer your patients for prompt, courteous, cost effective, and professional service.

INDIANAPOLIS

Methodist Hospital
1701 N. Senate Avenue
Methodist Professional Center
1801 North Senate Avenue
(317) 929-3580

Methodist Hospital Breast Cancer
Screening Program
(317) 929-5000

Eagle Highlands Radiologic Services
6920 Parkdale Place
Suite 111
(317) 291-4411

Lakeview Radiologic Services
9002 North Meridian Street
Suite 110
(317) 844-6944

BROWNSBURG

Brownsburg Radiologic Services
1375 North Green Street
Suite 200
(317) 852-3222



COLUMBUS

(Radiation oncology only)
Bartholomew County Hospital
2400 East Seventeenth Street
(812) 376-5361

CRAWFORDSVILLE

Culver Union Hospital
1710 Lafayette Road
(317) 364-3146

GREENSBURG

Decatur County Memorial Hospital
720 North Lincoln Street
(812) 663-1156

KOKOMO

(Radiation oncology only)
Howard Community Hospital
3500 South Lafountain Street
(317) 453-8189

TERRE HAUTE

(Radiation oncology only)
Union Hospital
1606 North Seventh Street
(812) 238-7504



RADIOLOGIC SPECIALISTS OF INDIANA, INC.

All Physicians Board Certified.

CLINICAL & ANATOMIC PATHOLOGY

The Medical Laboratory

of Drs. Thornton-Haymond-Costin-Buehl-Bolinger-Warner-McGovern-McClure-Hooker-Winkler
5940 West Raymond Street • Indianapolis, Indiana 46241

CHEMISTRY

MICROBIOLOGY

HEMATOLOGY

TOXICOLOGY

CYTOLOGY

HISTOLOGY

CUSTOMER SERVICE



Courier Service

24 hr. Pathology
Consultation

Assignment Accepted:
Medicare/Medicaid

BC/BS VIP and PC/USA,
Preferred Care, Prucare

18 Convenient Branch
Locations

CENTRAL TESTING FACILITY: 5940 W. Raymond St., Indianapolis, IN 46241

Phone: 317/248-2448

"Here Today To Serve You Tomorrow."

DOCTORS

This space is available.

For rates, write or call
INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

PULMONARY DISEASE

RESPIRATORY CONSULTANTS OF INDIANA

DAVID B. COOK, M.D., FCCP
CHRIS C. NAUM, M.D.

MICHAEL R. NIEMEIER, M.D., FCCP
THOMAS Y. SULLIVAN, M.D.
JOHN A. WARDEN, M.D., FCCP

ROBERT W. WELLER, M.D., FCCP
PATRICK E. WRIGHT, M.D., FCCP

Pulmonary Disease

Lung and lung-heart transplantation
Laser Bronchoscopy
Intra-bronchial radiation therapy
Trans-tracheal oxygen therapy
Complete rest and exercise
physiologic testing

Critical Care

Physicians ABIM certified in
critical care 24 hours/day
State-of-the-art eighty bed
intensive care facility

Hyperbaric Medicine

Diagnostic assessment
of local oxygen delivery
Treatment of disorders of
regional O₂ delivery and
utilization

Sleep Disorders

Clinical polysomnographer
Full-service polysomnography
laboratory

1801 N. SENATE BLVD., SUITE 400, INDIANAPOLIS, IN 46202 • OFFICE (317) 929-5820 • FAX (317) 929-3916
6920 PARKDALE PLACE, SUITE 215 • INDIANAPOLIS, IN 46254 • OFFICE (317) 328-6635 • FAX (317) 328-6640
GREENSBURG (812) 653-5533 • LEBANON (317) 873-2103 • RUSHVILLE (317) 932-4111 • TERRE HAUTE (812) 232-0564
AFTER HOURS ANSWERING SERVICE (317) 926-3466 OR 1-800-772-7788

1-800-321-LUNG • MONDAY - FRIDAY 8:30 A.M. - 4:30 P.M.

ALCOHOLISM TREATMENT

Eugene G. Roach, M.D.
Executive/Medical Director



Anderson Center
of Saint John's

1-800-435-9143 or (317) 646-8383

- Comprehensive Alcohol and Drug Treatment
- Separate Programs for Adolescents and Adults
- Free Assessment and Intervention

BREAST DISEASES

**INDIANA CENTER
FOR BREAST DISEASES**

DAVID W. PRICE, M.D.

Practice limited to Multidisciplinary Treatment of
BREAST DISEASES

Diagnosis
Consultation
Risk assessment
Surgical Oncology
of the breast

(317) 872-9580
8330 Naab Road, Suite 213
Indianapolis, IN 46260

Appointment by referral

■ physicians' directory

INTERNAL MEDICINE

NEPHROLOGY & INTERNAL MEDICINE, INC.

Thomas Wm. Alley, M.D., FACP	Douglas F. Johnstone, M.D.
George W. Applegate, M.D.	Wendy L. Kindig, M.D.
Richard Bloch, M.D.	LeRoy H. King, Jr., M.D. FACP
Charles B. Carter, M.D.	Barry F. Kriebel, M.D.
William H. Dick, M.D., FACP	Mary A. Margolis, M.D.
Theodore F. Hegeman, M.D.	Tim E. Taber, M.D.

**1801 N. Senate Blvd., Suite 355
Indianapolis, 46202
Tel: 317-924-8425**

By Physician Referral

Clinical Nephrology, Hemodialysis, Peritoneal Dialysis, Renal Transplantation, Metabolic Kidney Stone Disease, Hypertension, Fluid and Electrolyte Imbalance, Critical Care

HEMODIALYSIS

CHRONIC MAINTENANCE OUTPATIENT HEMODIALYSIS

DIALYSIS INSTITUTE OF ANDERSON
2629 Nichol Avenue
Anderson, Indiana 46011
317-649-0772

DIALYSIS INSTITUTE OF BEECH GROVE
3834 South Emerson Avenue
Indianapolis, Indiana 46203
317-787-3171

For further information contact
NEPHROLOGY & INTERNAL MEDICINE, INC.
1801 N. Senate Blvd., Suite #355
Indianapolis, Indiana 46202
317-924-8425

Outpatient renal consultation may be
scheduled at any location.

HAND SURGERY

JOHN C. KLEIN, M.D.

Specializing in the diagnosis and treatment of hand, wrist, and forearm disorders.

2727 N. Pennsylvania St. 317-925-1665
Indianapolis, IN 46205 Answered 24 hours

**Diplomate American Board of Orthopedic Surgery
with certificate of added qualifications in surgery of the hand.**

HAND SURGERY

SOUTH INDY HAND CENTER, P.C. **VIDYASAGAR S. TUMULURI, M.D., F.A.C.S.** CERTIFIED IN HAND SURGERY

Practicing hand and wrist surgery

South Sherman Professional Complex
3417 S. Sherman Dr., Suite F
Beech Grove, IN 46107
(317) 783-1319

Community Hospital South Prof. Bldg.
1550 E. County Line Rd., Suite 315
Indianapolis, IN 46227
(317) 888-0004

PSYCHIATRY

You Don't Have to Be Sick to Get Better



The Davis Psychiatric Clinic, Inc.

Child, Adolescent, Adult, Geriatric, Marital, Sexual, Forensic, Substance Abuse, Consultant Service and Psychological Testing and Evaluation

Larry Davis, M.D.

Judith Campbell M.D.

R. Peter Mohlman, M.D.

William E. Murray, M.D.

1431 N. Delaware 263-5200

Child and Adolescent 263-5204

North Side Office

11075 N. Pennsylvania 571-6011

24 Hour Emergency 631-3466

PSYCHIATRY

Eugene G. Roach, M.D.
Executive/Medical Director



Anderson Center

of Saint John's

201 Jackson Street

Anderson, Indiana 46016

1-800-435-9143 or (317) 646-8114

- Comprehensive Psychiatric Treatment
- Separate Programs for Adolescents, Adults and Older Adults
- Program for Dual Diagnosis

NEUROLOGY

Shirley M. Mueller, M.D.
General Neurology

Practice Dedicated Toward Problems Associated With Numbness-Weakness-Dizziness And Pain Including Headache

Testing Available

North: St. Vincent's Professional Bldg., Suite 726, Indianapolis
Tuesday, Thursday & Friday • 317-871-6000

South: Community South Professional Bldg., Suite M, Indianapolis
Monday & Wednesday • 317-887-7790

PERIPHERAL VASCULAR SURGERY



VASCULAR SURGERY, P.C.

Malcolm B. Herring, M.D.
Daniel R. LeGrand, M.D.
David L. Madison, M.D.
Sajjad M. Hussain, M.D.

St. Vincent Professional Building
8402 Harcourt Road
Suite 613
Indianapolis, Indiana 46260
Telephone (317) 871-6400
TOLL FREE (800) 336-6413

Carmel Medical Center
13450 North Meridian Street
Suite 160
Carmel, Indiana 46032
Telephone (317) 581-6020

Vascular
Diagnostics
Mobile
Non-invasive
Testing
™



The Vascular Lab

**NONINVASIVE
VASCULAR TESTING**

The vascular lab offers a full spectrum of diagnostic vascular testing services, including the new addition of color computed sonography, supported by the entire team of:

John F. Ansbro, M.D. • Alan T. Marty, M.D. • H. Dan Adams, M.D.
Richard A. Murrell, M.D. • Daniel B. Daniels, M.D. • Jay Tuna, M.D.

Cardiovascular Surgery Inc.

350 West Columbia
Suite 350
Evansville, Indiana 47710
812-423-2395

■physicians' directory

ASTHMA & ALLERGY

FRANK WU, M.D.



DIPLOMATE,
AMERICAN BOARD
OF ALLERGY &
IMMUNOLOGY

St. Vincent Professional Building
8402 Harcourt Road, Suite 606
Indianapolis, Indiana 46260
(317) 872-4213

ORTHOPAEDIC SURGERY

JAMES L. KAISER, M.D.



- ORTHOPAEDIC SURGERY
- FRACTURES
- BACK SURGERY
- FOOT SURGERY
- ARTHROSCOPIC SURGERY

Certified American Board
Of Orthopaedic Surgery

5626 East 16th Street
Indianapolis, IN 46218

(317) 352-0176

OFFICE ANSWERS DAY & NIGHT

5626 E 16
82nd & Shadeland
If No Answer Call

352-0176
352-0176
543-6089

ONCOLOGY



Oncology Associates

Michael A. Cross, M.D.
Board Certified, Radiology (Therapeutic)

John R. Pancoast, M.D.
Board Certified, Internal Medicine
and Medical Oncology/Hematology

John F. Sacco, M.D.
Board Certified, Internal Medicine
and Radiology (Therapeutic)

Offering comprehensive cancer care, including:

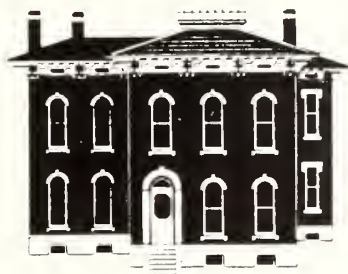
- Cancer Detection
- Chemotherapy
- Radiation Therapy (Linear Accelerator)
- Biologic Therapy
- Education and Support Services
- Hospital, Home and Hospice Care

Dearborn County Hospital Professional Building
606 Wilson Creek Road, Suite 130
Lawrenceburg, Indiana 47025
(812) 537-1911

Oncology Associates' 16 physician members have additional offices in Cincinnati, Montgomery and Middletown, Ohio; and Crestview Hills, Kentucky. The practice offers outpatient care and clinics in 11 hospitals throughout the Tri-State area.

ONCOLOGY — HEMATOLOGY

**INDIANA ONCOLOGY HEMATOLOGY
CONSULTANTS**



1-800-ONC-HEME
1-800-662-4363

Central: 317-927-5770
St. Francis: 317-783-8509

ADULT ONCOLOGY HEMATOLOGY — CENTRAL OFFICE

1828 N. Illinois Street Indianapolis, IN 46202 927-5770

Laurence H. Bates, M.D.

Gregory W. Smith, M.D.

William M. Dugan, Jr., M.D.

William H. Bond, M.D.

Redmond P. Hogan, III, M.D.

PEDIATRIC ONCOLOGY HEMATOLOGY — CENTRAL OFFICE

1828 N. Illinois Street Indianapolis, IN 46202 927-5770

Arthur J. Provisor, M.D.

Deborah S. Provisor, M.D.

ADULT ONCOLOGY HEMATOLOGY — ST. FRANCIS OFFICE

1600 Albany — Medical Clinic Bldg. Beech Grove, IN 46107 783-8509

Redmond P. Hogan, III, M.D.

Randall C. Trowbridge, M.D.

Gregory W. Smith, M.D.

*Central Office Located in the Byram Gates Middleton House
Listed on the National Register of Historic Places*

RADIATION ONCOLOGY



Physicians:
ROGER ROBISON
TAE CHUNG

Radiation Oncology Services for Southwest Indiana

VINCENNES
Good Samaritan Hospital
(812) 885-3939

TERRE HAUTE
Regional Hospital
(812) 237-9326

ROGER ROBISON, M.D., F.A.C.P.
M.D. Anderson, 1980
Certified: Radiation
Oncology
Medical Oncology

TAE CHUNG, M.D.
Chicago Hines, V.A., 1976
Certified: Radiation
Oncology

RADIATION ONCOLOGY

TRI-STATE RADIATION ONCOLOGY

Evansville Cancer Center
Evansville, Indiana
(812) 474-1110



Welborn Cancer Center
Evansville, Indiana
(812) 426-8373

AL KORBA, M.D.; ALY RAZEK, M.D.
SHANNON LAMB, M.D.; PRAMOD V. PRABHU, M.D.

★ ★ ★ ★ ★

Tri-County Cancer Care Center
Jasper, Indiana
(812) 482-2212
DEV DAS SHETH, M.D.

Tri-County Cancer Care Center
Princeton, Indiana
(812) 386-6663
MOISES DOMINGO, M.D.

★ ★ ★ ★ ★

Olney Cancer Center
Olney, Illinois
(618) 392-3050
MOISES DOMINGO, M.D.

Harrisburg Oncology Associates
Harrisburg, Illinois
(618) 252-5126
MANJU GUPTA, M.D.

★ ★ ★ ★ ★

Radiation Oncology
Owensboro, Kentucky
(502) 926-7228
TRISTAN BRIONES, M.D.

Henderson Cancer Center
Henderson, Kentucky
(502) 827-0255
PRAMOD V. PRABHU, M.D.

★ ★ ★ ★ ★

In Indiana 1-800-843-7117 • Out of Indiana 1-800-331-9294
24-hour answering service (812) 476-1367

TRANSPLANTATION

*Transplantation offers patients
with end-stage organ disease their only
opportunity for true rehabilitation...*

Methodist Transplant Center
24-hour referral: 800 772-7788



The Difference is Experience

P.O. Box 1367
1701 N. Senate Blvd.
Indianapolis, Indiana 46206

Heart Transplantation

Surgical Director: **Harold Halbrook, M.D.**

Surgeons: John Fehrenbacher, M.D.,
Daniel Beckman, M.D., David Hormuth, M.D.

Program Cardiologist: Douglas Pitts, M.D.

Kidney Transplantation Pancreas Transplantation

Surgical Director: **Brian Haag, M.D.**

Surgeons: Larry Stevens, M.D.,
Dale A. Rouch, M.D.

Program Nephrologist: Charles Carter, M.D.

Lung Transplantation

Surgical Director: **Harold Halbrook, M.D.**

Surgeons: John Fehrenbacher, M.D.,
Daniel Beckman, M.D., David Hormuth, M.D.

Program Pulmonologist:

Michael Niemeier, M.D.

Liver Transplantation

Surgical Director: **Dale A. Rouch, M.D.**

Surgeons: Larry Stevens, M.D.,
Brian Haag, M.D.

Program Pediatric Gastroenterologist:

Susan Maisel, M.D.

Program Hepatologist: Stephen C. Pappas, M.D.

Bone Marrow Transplantation

Co-Director: Luke Akard, M.D.

Co-Director: Jan Jansen, M.D., Ph.D.

Corneal Transplantation

Surgical Director: **Stephen Johnson, M.D.**

Tissue/Bone Bank

Surgical Director: **David A. Fisher, M.D.**

ORTHOPAEDIC SURGERY

TRADITION



ORTHOPAEDICS INDIANAPOLIS

*"CELEBRATING THREE DECADES
OF ORTHOPAEDIC EXCELLENCE"*

DONALD S. BLACKWELL, M.D.
F.R. BRUECKMANN, M.D., F.A.C.S.
ANTHONY R. LASICH, M.D.
WILLIAM O. IRVINE, M.D.
JOSEPH C. RANDOLPH, M.D.
DONALD E. RUSSELL, M.D.
MARK R. STEVENS, M.D.
TERRY R. TRAMMELL, M.D.
ANDREW J. VICAR, M.D.
VINCENT L. FRAGOMENI, M.D.
JOHN K. SCHNEIDER, M.D.
JOSEPH R. BAELE, M.D.
SANFORD S. KUNKEL, M.D.
DAVID A. FISHER, M.D.
D. KEVIN SCHEID, M.D.
MICHAEL F. COSCIA, M.D.
DEAN C. MAAR, M.D.
DAVID S. BROKAW, M.D.
HENRY G. STEIN, M.D., F.A.C.S.
ORTHOPAEDIC SURGEONS
ROBERT C. GREGORI, M.D.
PHYSICAL MEDICINE & REHABILITATION

JOINT RECONSTRUCTION
TRAUMA
FRACTURE CARE
SPORTS MEDICINE
SCOLIOSIS
SPINAL SURGERY
SHOULDER SURGERY
HAND SURGERY
FOOT SURGERY
ARTHROSCOPIC SURGERY
PEDIATRIC ORTHOPAEDICS
ADULT ORTHOPAEDICS
ILIZAROV LIMB LENGTHENING
& DEFORMITY CORRECTION

ORTHOPAEDICS INDIANAPOLIS
1801 N. SENATE, SUITE 200
INDIANAPOLIS, IN 46202
317-923-5352
1-800-223-3381
FAX: 317-924-0115
INDIANAPOLIS•
ZIONSVILLE•DANVILLE
SPEEDWAY•GREENCASTLE

ORTHOPAEDICS & SPORTS MEDICINE

Hoosier Orthopaedics & Sports Medicine, P.C.

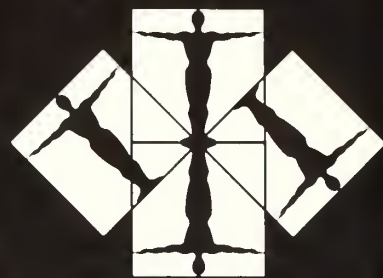
Total Joint Replacement
Athletic Injuries and Sports Medicine
Arthroscopic Surgery
Pediatric and Adult Orthopaedics
Fracture Care/Trauma

Reconstructive Surgery of the Foot and Ankle
Reconstructive Surgery of the Shoulder or Knee
Back Surgery
General Orthopaedics

Office Answers Day and Night

13450 North Meridian Street, Suite 355, Carmel, Indiana 46032
(317) 575-2705

8330 Naab Road, Suite 234, Indianapolis, Indiana 46260
(317) 870-7075



Robert T. Clayton, M.D.

Robert E. Cravens, M.D.

John E. Garber, M.D.

Robert M. Palmer, M.D.

Frank B. Throop, M.D.

Thomas F. Trainer, M.D.

COMPREHENSIVE REHABILITATION

We're Working to Make Life Better

At Kokomo Rehabilitation Hospital, we're committed to only one specialized field – rehabilitation medicine.

This central focus means your patients receive the therapy and care needed to restore their lives to the fullest extent possible.



**Kokomo
Rehabilitation
Hospital**

Our newly opened, 60-bed hospital features sophisticated high tech equipment, a total barrier-free environment and highly trained therapists.

Give us a try. Your patients and you will be pleased with the results.

– William J. Lester, MD,
Medical Director

Bringing the Quality Back to Life for Patients Affected by:

Stroke • Traumatic Brain Injury • Spinal Cord Injury • Amputation • Orthopedic Disorders • Neurological Disorders • Arthritis • Back and Neck Injuries • Chronic Pain • Multiple Trauma • Return to Work
• Carpal Tunnel Syndrome and other Cumulative Trauma Disorders

829 Dixon Road • Kokomo, Indiana 46901
General Hospital Information
(317) 452-6700

For Referral or Admission Information
1-800-886-LIFE

A Continental Medical Systems Facility

DOCTORS

This space is available.

For rates, write or call

INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

MULTI-SPECIALTY GROUP PRACTICE

Addictionology
Allergy
Cardiovascular Diseases
Dermatology
Endocrinology
Family Practice
Gastroenterology
Gynecology
Hematology-Oncology
Internal Medicine
Neurology
Nephrology
Nuclear Medicine
Obstetrics
Ophthalmology
Orthopedics
Otolaryngology
Pediatrics
Psychiatry
Pulmonary Medicine
Rheumatology
Surgery
Urology



**Welborn
Clinic**

421 Chestnut Street
Evansville, Indiana 47713
(812)426-9440

Toll-free in Indiana:
1-800-521-0269

Westside Family Practice Ctr.
(812)429-1818

Welborn Clinic East
(812)474-7123

Welborn Clinic Highland
(812)426-9565

In Newburgh:
Welborn Clinic Newburgh
(812)853-7391

In Reo:
Reo Family Practice Center
(812)649-5061

DERMATOPATHOLOGY

DERMATOPATHOLOGY LABORATORY

Larry J. Buckel, M.D.
Robert M. Hurwitz, M.D.

Howard R. Gray, M.D.
William B. Moores, M.D.



Diplomates of the American Boards
of
Dermatology and Dermatopathology

Specializing in
Inflammatory Skin Diseases
and
Neoplasms of the Skin

9202 North Meridian Street
Suite 215

Approved for and Accept
Medicare and Medicaid
Assignment

Indianapolis, Ind. 46260
(317) 843-2204

UPS Mailers and Courier Service Available

DOCTORS

This space is available.

For rates, write or call

INDIANA MEDICINE,
322 Canal Walk,
Indianapolis, IN 46202-3252,
(317) 261-2060 or 1-800-257-ISMA.

■ from the museum

The Indiana Medical History Museum greatly appreciates the donations made each year during the museum's annual operating support campaign.

Contributions to the annual campaign differ from the membership donations physicians make through the Indiana State Medical Association. Those donations occur when physicians check the "Med Mus" box on the association's dues form.

The museum conducts the annual campaign to help raise additional funds to support the various aspects of the museum's

operations. Individual and corporate contributions enable the museum to remain open and provide diverse programs.

Besides the annual campaign, the Indiana Medical History Museum also conducted a capital campaign last year to raise funds for the \$10,000 matching grant awarded by the Indiana Department of Natural Resources Division of Historic Preservation and Archaeology. The U.S. Department of the Interior provided money for the grant program through the Historic Preservation Fund.

The museum used the match-

ing grant to install a new flat roof, refurbish the building's skylights and make other improvements to better preserve the museum's historic structure. The grant also enabled the museum to install automatic change-over thermostats to improve control of the building's interior temperature and to construct a handicapped-access ramp.

The Indiana Medical History Museum greatly appreciates the following individual and corporate contributors who donated last year for the annual operating campaign and the capital campaign:

Annual Operating Support Campaign contributors:

Mary Keller Ade, M.D.
George W. Applegate, M.D.
Thomas L. & Judith A. Arms
Robert D. Arnold, M.D.
Eldon E. Baker, M.D.
Gregorio R. Baluyot, M.D.
Helen B. Barnes, M.D.
Charles M. Beasley Jr., M.D.
Beeson Facial Surgery
Angenieta A. Biegel, M.D.
Ronald G. Blankenbaker, M.D.
Ann C. Blunk
William L. Bridges, M.D.
Mr. & Mrs. Glen F. Brown
Rebecca L. Bushong, M.D.
William K. Byrum
Mary Ann Cates
Central Pathology Laboratory
Dr. Jeffery L. & Deborah Christie
Oren S. Cooley
Clyde G. Culbertson, M.D.
James R. Daggy, M.D.
Naomi L. Dalton, M.D.
Walter J. Daly, M.D.
Mrs. Joseph B. Daugherty
J. Frederick Doepker, M.D.
Ronald H. Doneff, M.D.
Eli Lilly & Co. Foundation
Drs. John & Anne Eliades
Jack Farr, II, M.D.
Henry Feuer, M.D.
A. Alan Fischer, M.D.
John L. Franklin
Richard E. Fry, M.D.
David M. Gibson, M.D.
M. Arthur Grant, M.D.
Robert P. & Dr. Vicki L. Graves
Kenneth L. Gray, M.D.

Morgan E. Greene, M.D.
John H. Greist, M.D.
Gilbert Gutwein, M.D.
Paula A. Hall, M.D.
Richard C. Harruff
C. W. Hasewinkel, M.D.
Mrs. Nicholas W. Hatfield
Edgar A. Hawk, M.D.
Jack W. Higgins, M.D.
John H. Hines, M.D.
Larry G. Hitchcock, M.D.
Dr. & Mrs. Robert P. Hooker
Lester H. Hoyt, M.D.
Jesse D. Hubbard, M.D.
Indiana Association of Pathologists
Indiana Bell
William O. Irvine, M.D.
Glenn W. Irwin Jr., M.D.
Jackson County Medical Auxiliary
Mrs. John E. Jesseph
A. Cedric Johnson Jr., M.D.
Dr. & Mrs. Walter W. Jolly
Anabel R. Jones, M.D.
Dr. & Mrs. David A. Josephson
Walter E. Judson
John U. Keating, M.D.
Gerald T. Keener Jr., M.D.
Dr. & Mrs. Robert M. Kelsey Jr.
Clyde B. Kernek, M.D.
Byron Kilgore Jr., M.D.
John C. Klein, M.D.
Dr. & Mrs. Jay W. Lang
Dr. Robert M. LaSalle Jr.
Mrs. Goethe Link
Shirley D. Littlefield, M.D.
Thomas E. Lunsford, M.D.
John D. MacDougall, M.D.
Calvin J. Maestro Jr., M.D.

Griffith Marr, M.D.
Robert A. McCready, M.D.
Katherine M. McDonell
Dr. & Mrs. Robert A. McDougal
Dr. Philip F. & Jacqueline Merk
Randall D. Miller
Rhonda Miller
Sherman A. Minton Jr., M.D.
Dr. & Mrs. Richard T. Miyamoto
Glenn D. Moak, M.D.
John M. Moore, M.D.
Dr. & Mrs. Lewis E. Morrison
Jans Muller, M.D.
M. Marguerite Murphy
Stephen R. Myron, M.D.
Raymond J. O'Brien, M.D.
Dr. & Mrs. Norris V. Owen
Pancner Psychiatric Services
Dr. John M. & Judith A. Paris
Jean Perrin, M.D.
T. Neal Petry, M.D.
Emmett C. Pierce, M.D.
Dr. & Mrs. Stafford W. Pile
Dr. & Mrs. John N. Pittman
John E. Pless, M.D.
Edwin E. Pontius, M.D.
Ward E. Poulos, M.D.
Dr. & Mrs. Marvin E. Priddy
Drs. Robert D. & Ben B. Raney
Frank W. Ratcliff, M.D.
Robert G. Reed Jr., M.D.
Dr. & Mrs. Raymond D. Rice
Stephen R. Richwine
Mrs. Wayne L. Ritter
John A. Robb, M.D.
Robert J. Rohn, M.D.
Dr. & Mrs. Floyd T. Romberger Jr.
Dr. & Mrs. Max H. Rudicel

William F. Ruoff, M.D.
Dr. & Mrs. Carl N. Rutt
Richard L. Scales, M.D.
Theodore F. Schlaegel Jr., M.D.
Dr. & Mrs. Richard B. Schnute
Charles A. Schreiber
Dr. & Mrs. Dale M. Schulz
Dr. & Mrs. Dwight W. Schuster
John L. Searight, M.D.
John H. Seward, M.D.
Dr. & Mrs. William M. Sholty
Harry Siderys, M.D.
James E. Simmons, M.D.
John D. Slack, M.D.
Mr. & Mrs. Richard M. Small
Alan F. Smith, M.D.
Dr. James W. & Nancy C. Smith
Dr. & Mrs. Lewis E. Smith Jr.
William S. Sobat, M.D.
Mary A. Soule, M.D.
Dr. & Mrs. Carl B. Sputh
Frederick B. Stehman, M.D.
James B. Steichen, M.D.
Vergil K. Stoelting, M.D.
Dr. & Mrs. John G. Suelzer
Charles E. Test, M.D.
Hugh K. Thatcher Jr., M.D.
David R. Thiel
Gayle Thornbrough
Dr. & Mrs. Walter B. Tinsley Jr.
Charles E. Tomich, D.D.S.
Josephine Van Fleet, M.D.
Charles J. Van Tassel Jr., M.D.
Dr. & Mrs. Robert W. Vermilya
T. Max Warner, M.D.
Mrs. Robert T. Whitcraft
Mrs. Donald J. White
Edward R. Wills, M.D.

■ from the museum

Peter L. Winters, M.D.
Michael L. Yacko, M.D.
William S. Yocum Sr., M.D.
Dr. & Mrs. Don B. Ziperman

Capital Campaign contributors:

George W. Applegate, M.D.
Eldon E. Baker, M.D.
Ronald G. Blankenbaker, M.D.
William L. Bridges, M.D.
John M. Brown, M.D.
Oren S. Cooley
Carolyn A. Cunningham, M.D.
Helen G. Czenkusch, M.D.
Naomi L. Dalton, M.D.
J. Frederick Doecker, M.D.
Ronald H. Doneff, M.D.
John N. Eble, II, M.D.
Eli Lilly & Co. Foundation

David M. Gibson, M.D.
John H. Greist, M.D.
Dr. & Mrs. Robert C. Hall
Maynard K. Hine, D.D.S.
Dr. & Mrs. Robert P. Hooker
Lester H. Hoyt, M.D.
Jesse D. Hubbard, M.D.
Indiana Association of Pathologists
Indiana Bell
Indiana State Medical Association
Glenn W. Irwin Jr., M.D.
John U. Keating, M.D.
Thomas E. Lunsford, M.D.
Griffith Marr, M.D.
Katherine M. McDonell
Charles M. Orr, M.D.
Dr. & Mrs. Norris V. Owen
Dr. & Mrs. John N. Pittman
Edwin E. Pontius, M.D.

Stephen R. Richwine
James F. Rimel, M.D.
John A. Robb, M.D.
Robert J. Rohn, M.D.
Rudolph Rouhana, M.D.
Alan D. Schmetzer, M.D.
Dr. & Mrs. Dwight W. Schuster
John H. Seward, M.D.
Dr. & Mrs. William M. Sholty
John D. Slack, M.D.
Mr. & Mrs. Richard M. Small
Dr. & Mrs. Lewis E. Smith Jr.
Dr. & Mrs. Carl B. Sputh
Joseph L. Steinem, M.D.
David R. Thiel
Gayle Thornbrough
Dr. & Mrs. Walter B. Tinsley Jr.
Josephine Van Fleet, M.D.
Vernon A. Vix, M.D. ┘



CREATE A MEDICAL BREAKTHROUGH.

Become an Air Force physician and find the career breakthrough you've been looking for.

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay per year

Today's Air Force provides medical breakthroughs. Find out how to qualify as a physician or physician specialist. Call

**USAF HEALTH PROFESSIONS
COLLECT
(317) 848-5830**



■ cme calendar

St. Vincent Hospital

St. Vincent Hospital and Health Care Center in Indianapolis will sponsor these CME courses:

- Dec. 4** - Psychodrama Workshop: Catharsis from Aristotle to Moreno, Action Methods Training Center, Carmel.
- Jan. 23** - Winter Seminar in Pulsed Dye Cutaneous Laser Surgery, St. Vincent Hospital, Indianapolis.
- Apr. 24-25** - 11th Annual Spring Seminar in Dermatopathology, St. Vincent Hospital, Cooling Auditorium, Indianapolis.

For details, call Beth Hartauer, (317) 871-3460.

Aesthetic Surgery

The 1992 Aesthetic Surgery of the Aging Face seminar will be held March 3 through 7 at the Radisson Hotel in Indianapolis. The seminar is sponsored by Beeson Facial Plastic & Reconstructive Surgery in Indianapolis and the American Academy of Facial Plastic & Reconstructive Surgery.

For more information, call Carrie Van Dyke, (317) 846-2988.

St. Mary's Medical Center

St. Mary's Medical Center in Evansville will sponsor these CME courses:

- Feb. 18** - The MacKenzie Lecture: Obstetrical Ultrasound Examinations, St. Mary's Medical Center Amphitheatre, Evansville.
- Mar. 4** - The G.I. Seminar: The Ulcers, St.

Mary's Medical Center Amphitheatre, Evansville.

For more information, call (812) 479-4468.

Indiana University

The Indiana University School of Medicine will sponsor these courses:

- Dec. 4-5** - Facial Plastic Surgery, University Place Conference Center, Indianapolis.
- Dec. 5** - Acute Pain Management in Pediatrics, University Place Conference Center, Indianapolis.
- Dec. 5** - Age-Related Issues: Treating the Mature Hypertensive Patient, Embassy Suites Downtown, Indianapolis.

For more information, call (317) 274-8353.

University of Michigan

The University of Michigan Medical School will sponsor these CME courses:

- Jan. 23** - Update on Pediatric Surgery in the Primary Care Office, Towsley Center, University of Michigan, Ann Arbor.
- Mar. 16-20** - Family Practice 1993: 17th Annual Spring Review Course, Towsley Center, University of Michigan, Ann Arbor.

For more information, call Robin Rice, (313) 763-1400.

St. Luke's Medical Center

The Rush-Presbyterian - St. Luke's Medical Center in Chicago will

sponsor Neurology for the Non-Neurologist Dec. 9 through 11 at the Embassy Suites in Chicago.

For more information, call the Office of CME, (312) 942-7095.

Ohio State University

The Ohio State University College of Medicine in Columbus will sponsor these CME courses:

- Dec. 5-6** - Nutrition for Clinical Practice and Everyday Living: 1992, Hyatt on Capitol Square, Columbus, Ohio.
- Feb. 20** - Obsessive/Compulsive Disorders, Hyatt on Capitol Square, Columbus, Ohio.

For more information, call 1-800-492-4445.

Washington University

The Washington University School of Medicine in St. Louis will sponsor these CME courses:

- Dec. 5** - Hypertension, The Ritz-Carlton Hotel, St. Louis.
- Dec. 12** - Management of Hypercholesterolemia: Goals and Strategies, Adam's Mark Hotel, St. Louis.
- Feb. 27** - Women and Men in Health Care, Washington University Medical Center, St. Louis.
- Mar. 27-29** - Aesthetic Plastic Surgery: Facial and Body Contouring, The Ritz-Carlton Hotel, St. Louis.

For more information, call the Office of CME, 1-800-325-9862. □

Breast health brochure targets special audience

The Women's Health Task Force, an Indianapolis-based coalition dedicated to improving the health of Marion County women, has published a breast health brochure for women with limited reading skills.

The brochure was made possible through funds raised from the 1992 Susan G. Komen Race for the Cure, an annual running and walking event to benefit breast cancer research, screening and education.

To obtain copies of the brochure, call Jane Ambro or Gina Setty at the Little Red Door Cancer Agency, (317) 925-5595.

Political candidates visit orthopaedic surgeons' office

Two Democratic political candidates visited the 18 physicians of Orthopaedics Indianapolis during their campaigns.

Pam Carter, Democratic candidate for Indiana attorney general, participated in a round table discussion on such issues as medical malpractice, the Indiana Health Policy Commission and peer review. Joe Hogsett, Democratic candidate for U.S. Senate, discussed national health care reform, Medicare, Medicaid, personal income tax and peer review with the physicians. Invitations were also issued to the opposing candidates, but both declined. Neither forum was a fund-raiser.

Information, support available on osteogenesis imperfecta

The Osteogenesis Imperfecta Foundation offers information to doctors treating patients with the genetic bone disorder.

Symptoms of osteogenesis imperfecta (OI) are bones that fracture easily, short stature, hearing loss, scoliosis and other deformities, brittle teeth and respiratory complications. Because the disorder is relatively rare, affecting about 30,000 Americans, a physician may see only one or two people with OI in his practice.

The foundation offers accurate information about OI through literature, videos, a quarterly newsletter and biennial national conferences. Support services and funding for research are other services.

Physicians are encouraged to tell their patients with OI about the foundation. For more information, contact the Osteogenesis Imperfecta Foundation, 5005 W. Laurel St., Suite 210, Tampa, FL 33607, (813) 282-1161.

Two Indianapolis trauma centers earn verification

Indianapolis now has two of the 70 trauma centers in the United States verified as Level 1 by the American College of Surgeons. They are Methodist Hospital and Wishard Memorial Hospital.

The Level 1 verification results from reviews of the hospitals' commitment and ability to provide top quality, wide-ranging trauma services. The process is voluntary.

Applications available for diabetes research grants

The Juvenile Diabetes Foundation International has announced the availability of grants in diabetes research for the funding year Sept. 1, 1993, to Aug. 31, 1994.

Applications are available

from Grant Administrator, Juvenile Diabetes Foundation International, 432 Park Ave. South, New York, NY 10016, (212) 889-7575. Completed applications must be received by March 1, 1993.

NIH offers consensus report on early melanoma

A consensus development statement on the diagnosis and treatment of early melanoma may be obtained from the National Institutes of Health (NIH) Office of Medical Applications of Research.

The report was prepared by a panel of experts who considered scientific evidence presented at a Consensus Development Conference at the NIH.

To receive a free, single copy of the statement, contact William H. Hall, Director of Communications, Office of Medical Applications of Research, Federal Building, Room 618, 7550 Wisconsin Ave., Bethesda, Md., 20205, (301) 496-1144.

Alzheimer's disease center has new toll-free number

The Alzheimer's Disease Education and Referral Center has announced a new toll-free telephone number for information on Alzheimer's. The new number is 1-800-438-4380.

Health professionals and the public can call to ask questions about Alzheimer's disease, identify resources and materials, receive a calendar of upcoming conferences, learn about clinical trials sponsored by the National Institute on Aging and order free publications. Information specialists answer calls between 8:30 a.m. and 5 p.m. weekdays. □

■ obituaries

Adriano A. Agana, M.D.

Dr. Agana, 73, a Gary general practitioner, died Aug. 31.

He was a 1945 graduate of the Faculty of Medicine and Surgery University in the Philippines.

Dr. Agana, who practiced in Gary for 36 years, was president of the Indiana Philippine Medical Association and a member of the Philippine Medical Association in Chicago, the Association of Philippine Physicians in America and the Asian American Medical Association in Indiana. He had been medical director of the Lake County Convalescent Center and a physician for U.S. Steel in Gary.

Ralph W. Elston, M.D.

Dr. Elston, 93, a retired Fort Wayne surgeon, died July 10 in Towne House Health Center in Fort Wayne.

He was a 1924 graduate of Rush Medical College and a World War I Army Medical Corps veteran. He was a recipient of the Purple Heart.

Dr. Elston retired in 1969 after 40 years as a surgeon. He was certified by the American Board of Surgery and was a former director of the Medical Protective Co.

Howard M. Faust Jr., M.D.

Dr. Faust, 60, an Anderson family practitioner, died Aug. 14 at Methodist Hospital Indianapolis.

He was a 1957 graduate of the Indiana University School of Medicine.

Dr. Faust opened his practice in Anderson in 1958. He retired in 1991 from the staff at Community Hospital in Anderson but continued his private practice. He was the author of two books, *Communism and You* and *The History of Medicine in Madison County, Indiana*. He invented a board

game, *Wander Indiana*, in which players answered Indiana trivia questions and moved Indianapolis 500-style cars around a map of the state. He was a member of the Association of American Physicians and Surgeons and several historical groups.

Milton H. Gustafson, M.D.

Dr. Gustafson, 79, a retired Muncie dermatologist, died Aug. 5 in Community Care Center in Muncie.

He was a 1940 graduate of Case Western Reserve University School of Medicine and served as an Army flight surgeon during World War II.

Dr. Gustafson practiced in Muncie from 1948 to 1984 and was on the staff of Ball Memorial Hospital for more than 25 years. He was a member of the Academy of Dermatology, the Chicago Dermatology Society and the Indiana Dermatology Society.

Homer L. Life, M.D.

Dr. Life, 88, a retired New Castle surgeon, died July 13 at Ball Memorial Hospital in Muncie.

He was a 1936 graduate of the Indiana University School of Medicine.

Dr. Life had a surgery practice at Henry County Hospital in New Castle for more than 30 years. He was named New Castle's Outstanding Citizen in 1949 and was a leader in the movement to establish a school for crippled children. He was president of the Kiwanis Club in 1950 and 1951.

Georgia B. Mitchell, M.D.

Dr. Mitchell, 65, a Gary family practitioner, died June 23 at Methodist Hospital Southlake in Merrillville.

She was a 1958 graduate of

Meharry Medical College.

Dr. Mitchell was the first black woman general practitioner in northwest Indiana. She was owner and president of the Broadway Medical Corp. and the first woman to head the division of family practice at the Methodist Hospitals in Lake County. She was a member of the American Medical Women's Association, the Alpha Omega Alpha Honor Medical Society and the NAACP Million Dollar Club.

Earl J. O'Brian, M.D.

Dr. O'Brian, 66, a retired Indianapolis family practitioner, died Aug. 31 in St. Vincent Hospital.

He was a 1951 graduate of the Indiana University School of Medicine and an Army veteran of the Korean War.

Dr. O'Brian, a founder of the Northwest Medical Center in Indianapolis, retired in 1989, after 30 years in practice. He was a member of the American Academy of Family Physicians.

H. Jerome Rietman, M.D.

Dr. Rietman, 64, a retired Evansville psychiatrist, died June 28 at Deaconess Hospital in Evansville.

He was a 1952 graduate of the St. Louis University School of Medicine.

Dr. Rietman, who retired from private psychiatric practice in 1989, had worked at Evansville State Hospital. He was president of the Deaconess Hospital medical staff in 1966 when the hospital opened its first closed mental health unit. He was a member of the American Psychiatric Association.

David B. Templin, M.D.

Dr. Templin, 80, a retired Crown Point family practitioner, died

Aug. 18 at St. Anthony Hospital in Crown Point.

He was a 1937 graduate of the Pritzker School of Medicine at the University of Chicago.

Dr. Templin, a past president of the Lake County Medical Society, had practiced medicine in Lake County for more than 50 years, retiring in 1989. He was the founder of the Lowell Clinic and had served as medical direc-

tor at the Lutheran Home in Crown Point.

Roger G. Unzicker, M.D.

Dr. Unzicker, 52, a Middlebury family practitioner, died Aug. 9 at Methodist Hospital in Indianapolis.

He was a 1968 graduate of the University of Illinois College of Medicine.

Dr. Unzicker moved to the

Goshen area 20 years ago, after serving three years in medical mission work in East Africa. He was affiliated with Middlebury-Millersburg Family Physicians and was chief of staff at Goshen General Hospital from 1981 to 1982. He was a member of the American Academy of Family Physicians and a past secretary of the Mennonite Medical Association. □

Auto Buyers Network

The #1 priority at Auto Buyers Network is to provide you with an easy, timely, and affordable way to purchase your next new or used car, truck or van. Tell us the make and model vehicle that you prefer and **we** do the legwork. No more disputing with salesmen, wondering and worrying if you're getting a "good deal." We can even arrange leasing or financing utilizing the best rates available from several participating lenders.

▲ Personalized Service Statewide ▲

Auto Buyers Network

Bill Prewitt, ISMA Consultant

40 West 40th Street, Indianapolis, IN 46208

317/ 921-1537 or 800/736-0172

Dr. Charlotte M. Dugan, a Noblesville otolaryngologist, was elected a fellow of the American Academy of Otolaryngology – Head and Neck Surgery.

Dr. Frank Wu of Indianapolis was certified by the American Academy of Allergy and Immunology as an expert airborne pollen identifier. His office is the first certified pollen counting station in Indiana and is a part of the nationwide AAAI Aeroallergen Network.

Dr. Binh Q. Nguyen has joined the ophthalmology practice of **Dr. Larry H. Wolff** in Munster.

Dr. John P. McGoff was elected president of the Indiana Chapter of the American College of Emergency Physicians. He is chairman of Medical Associates, an emergency medicine practice in Indianapolis.

Dr. Douglas P. Zipes of the Indiana University School of Medicine in Indianapolis is co-author of *Progress in Cardiology* 5/2, published recently by Lea & Febiger.

Dr. Rick A. Robertson has opened a child and adolescent psychiatry practice at 7250 Clearvista Drive in Indianapolis.

Dr. Scott T. Miles has relocated his obstetrics, gynecology and infertility practice to 8937 Southpointe Drive in Indianapolis.

Activities and accomplishments of physicians at Northside Cardiology in Indianapolis include the following: **Dr. Anthony King** of the Kokomo office co-authored an article titled "Elevated Arterial Blood Pressure in Cardiac Tamponade" in the August issue of *The New England Journal of Medicine*. **Dr. Zachary I. Hodes** was elected a fellow of the scientific council of the American College of Angiology. **Dr. Tho-**

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

July 1992

Angel, Virgil E., Highland
Beard, Karen M., Danville
Jones, Anabel R., Lafayette
Luce, John W., Michigan City
Norins, Arthur L., Indianapolis
Pillai, Vijayan V., Bedford
Woodward, William M., Westville

August 1992

Allen, Deborah L., Indianapolis

Bluth, Steven A., South Bend
Bundy, Mary L., New Albany
Cordano, Angel, Evansville
Fisch, Gary R., Indianapolis
Hardin, Gregory T., Greenwood
Heck, Larry L., Indianapolis
Henley, Anne E., Kokomo
Rose, Stephen L., Evansville
Schoon, Paul G., Indianapolis
Shields, James K., Otterbein
Wilson, Fred M., Carmel

mas J. Linnemeier published an editorial on laser angioplasty in *The Journal of Catheterization and Cardiovascular Diagnosis*. **Dr. Eric N. Prystowsky** was the Dozer Visiting Professor at Ben-Gurion University in Israel and lectured at the Dead Sea during a two-day symposium. He was one of four invited lecturers at the 1992 Japanese Electrophysiology and Pacing Society meeting in Hiroshima and presented one of the Controversies in Cardiology debates at the national American College of Cardiology meeting in Dallas. **Dr. Prystowsky** also was appointed chairman of the national American Heart Association Committee on Electrophysiology and Electrophysiology from 1992 through 1994.

Dr. Gregory C. Kiray has joined Internal Medicine Associates of Indianapolis.

Dr. Richard D. Zeph, a Carmel facial plastic surgeon, has been certified by the American Board of Facial Plastic Surgery.

Dr. Zeph spoke on pretrichial forehead lifts and presented a videotape on fat injections at the American Academy of Facial Plastic Surgery-sponsored "Rejuvenation of the Face – 1992." He also moderated panel discussions on injectable fillers and the aging lip.

Dr. Ronald J. Caniglia has joined the facial plastic surgery practice of **Dr. Stephen W. Perkins** in Indianapolis to complete a year of specialized training through a fellowship program of the American Academy of Facial Plastic and Reconstructive Surgery.

Dr. Jeffrey Mossler and **Dr. Irwin Labin** have joined Indiana Heart Physicians, affiliated with St. Francis Hospital Center in Beech Grove.

Dr. Franklin D. Wilson, an Indianapolis orthopaedic surgeon, participated in the Arthroscopic Surgery of the Shoulder meeting in San Diego; he gave two lectures, was a member of two panel discussions and taught a cadaver

lab on rotator cuff repairs. He spoke on rotator cuff repairs at the fall meeting of the Arthroscopy Association of North America.

Dr. James A. Trippi, an Indianapolis cardiologist, received the Ray Sears Memorial Award from U.S. Sen. Richard Lugar. The award honors Hoosiers who exemplify the phrase "good health and good living" and is named for long-distance runner Ray Sears.

Dr. Vactor O. Connell, a Bourbon family practitioner, and his wife, Margaret, were grand marshals for the 1992 Bourbon Summerfest parade.

Dr. Maurice E. John, a Jeffersonville ophthalmologist, spoke at the Canadian Rockies Symposium on Cataract and Refractive Surgery in Calgary, Alberta. He explained improved surgical techniques, including a new surgical knife, the John Groover.

Dr. Philip D. Watson and **Dr. David L. Blemker** of Vincennes have been board certified in cardiology.

Dr. Timothy R. Williams of Vincennes has been board certified in anesthesiology and pain management.

Dr. Charles P. Taliercio, an Indianapolis cardiologist, was voted Internal Medicine Teacher of the Year and recipient of the 1991-1992 Distinguished Teacher Award by residents who recently completed their residencies at St. Vincent Hospital in Indianapolis.

Dr. Todd S. Weinstein of Logansport has been certified by the American Board of Surgery.

Dr. Frank Johnson has retired as director of the Marion County Health Department. He is continuing to practice obstetrics and

gynecology. □

New ISMA members

Chik Amechi, M.D., Fort Wayne, obstetrics and gynecology.

Thomas M. Banas, M.D., Fort Wayne, neurology.

Allan W. Barbish, M.D., Fort Wayne, gastroenterology.

Karen L. Beard, M.D., Danville, family practice.

Eric A. Burnett, M.D., Richmond, internal medicine.

Ralph F. Carbone, D.O., Willowbrook, Ill., anesthesiology.

Bennett B. Desadier, M.D., Indianapolis, obstetrics and gynecology.

Anthony J. DeRiso II, M.D.,

Fort Wayne, cardiovascular surgery.

Richard A. Gard, M.D., Kokomo, obstetrics and gynecology.

Kathryn A. Garner, M.D., Fort Wayne, obstetrics and gynecology.

Winston C. Gerig, M.D., Mishawaka, general surgery.

Thomas A. Guffy, M.D., Indianapolis, ophthalmology.

Frank E. Hawkins, M.D., Crawfordsville, anesthesiology.

Mark A. Hayes, M.D., Martinsville, family practice.

Thomas W. Huth, M.D., Richmond, internal medicine.

Lynn K. Jennings, M.D., Logansport, anesthesiology.

Babies are the Apple of his eye

The miracle of birth "never ceases to amaze" Eddie Apple, M.D. – even though he's delivered more than 9,000 babies.

The Salem general practitioner reached the 9,000 milestone Aug. 19 when he delivered a baby girl whose parents he also had delivered. Forty years of bringing babies into the world have not jaded his outlook. "I love to deliver babies," Dr. Apple says. "It's my favorite thing."

To set the record straight, he points out that he actually has delivered 9,000 babies at Washington County Memorial Hospital alone. If you include his deliveries at other hospitals and during his internship, the count is higher.

Dr. Apple delivered his first baby at the Salem hospital Aug. 24, 1952, about two weeks after he opened his practice in Salem.

Although he had once considered specializing in obstetrics and gynecology, economic realities prevailed. Specializing would have meant three more years of school, but with a wife and child to support, he couldn't wait that long to open a practice.

His deliveries have included two sets of triplets – all girls – and more than 80 sets of twins. Dr. Apple says it is not unusual for him to learn that he delivered the parents of the babies he's now delivering. He has also had at least one third-generation delivery.

Several parents have named their children after Dr. Apple. Many send him photographs of their children so he can see their progress. □

■ people

Jatinder N. Kaushal, M.D., Kokomo, gastroenterology.

Leonard J. Kibiloski, M.D., Elkhart, orthopaedic surgery.

Barry F. Kriebel, M.D., Indianapolis, nephrology.

Jerrold A. Laskin, M.D., Carmel, plastic surgery.

Christopher A. Leagre, M.D., Carmel, radiation oncology.

Susan Maisel, M.D., Indianapolis, gastroenterology.

Brent R. McIntosh, M.D., Beech Grove, orthopaedic surgery.

Antolin M. Montecillo, M.D., Clinton, family practice.

Kenneth G. Ney, M.D., Indianapolis, urological surgery.

Anne-Francis E. Nicol, M.D., Logansport, psychiatry.

Ramesh P. Patel, M.D., Princeton, internal medicine.

M.A. Quraishi, M.D., Austin, internal medicine.

David A. Rawling, M.D., South Bend, cardiovascular diseases.

John D. Reed Jr., M.D., Fort Wayne, diagnostic radiology.

Achyutananda Roy, M.D., Valparaiso, general surgery.

Gregory L. Schaefer, M.D., Martinsville, obstetrics and gynecology.

Douglas B. Smith, M.D., Indianapolis, rheumatology.

Byron J. Stephens, M.D., Fort Wayne, general surgery.

Paul N. Stewart, M.D., Indianapolis, child psychiatry.

Glenn A. Tuckman, M.D., Indianapolis, diagnostic radiology.

Susan L. Tuori, M.D., Fort Wayne, radiology.

Elizabeth W. Varsa, M.D., Fort Wayne, anatomic/clinical pathology.

Scott A. Wagner, M.D., Fort Wayne, anatomic pathology.

Edwin B. Watkins, M.D., Columbus, radiation oncology.

Patsy J. Webber Hunt, M.D., Indianapolis, obstetrics and gynecology.

Toni E. Wilkes, M.D., Indianapolis, obstetrics and gynecology.

Anil Yakhmi, M.D., Indianapolis, internal medicine.

Jeffery A. Yoder, M.D., Fort Wayne, general surgery.

Philip D. Zaneteas, M.D., Kokomo, physical medicine and rehabilitation.

Residents

Cezanne C. Allen, M.D., Indianapolis, dermatology.

Ralph M. Buschbacher, M.D., Carmel, physical medicine and rehabilitation.

Ronald J. Caniglia, M.D., Fishers, otolaryngology.

Cathy D. Carr, M.D., Indianapolis, obstetrics and gynecology.

Steven W. Carr, M.D., Indianapolis, anesthesiology.

Diane S. Cook, M.D., Elkhart, family practice.

Jeffrey J. Couture, M.D., Indianapolis, internal medicine and pediatrics.

James T. Fesenmeier, M.D., Indianapolis, neurology.

Robert S. Flint II, M.D., Indianapolis, neurology.

Douglas L. Franke, M.D., Indianapolis, internal medicine.

Asha K. Gupta, M.D., Indianapolis, family practice.

Moazzam W. Habib, M.D., Indianapolis, internal medicine.

Wade Hsu, M.D., Rochester, general surgery.

Madelein C. Kolar, M.D., Indianapolis, psychiatry.

Robert S. Kurtz, M.D., Cicero, anesthesiology.

Irwin N. Labin, M.D., Beech Grove, cardiovascular diseases.

Mark D. Lisby, M.D., Indianapolis, family practice.

Jeffrey C. Pauloski, M.D., Indianapolis, obstetrics and gynecology.

Todd A. Ryan, M.D., Indianapolis, internal medicine.

Rami Saydjari, M.D., Crawfordsville, general surgery.

Leslie K. Schutz, M.D., Indianapolis, physical medicine and rehabilitation.

John F. Wagner, M.D., Indianapolis, obstetrics and gynecology.

Mark L. Wellemeyer, M.D., Indianapolis, ophthalmology.

Michael E. Welling, M.D., Indianapolis, psychiatry. □

Index to Indiana Medicine volume 85

January through December 1992

MONTH	PAGES
January/February	1-100
March/April	101-184
May/June	185-270
July/August	271-358
September/October	359-466
November/December	467-546

SCIENTIFIC CONTRIBUTIONS:

C

Cardiac transplantation at IU Medical Center (Rigden, Faust, Brown, Mahomed, Kesler, Turrentine, O'Donnell)	414
Coronary-subclavian steal as a cause of dyspnea (Blemker, Trippi)	136

D

Delayed posttraumatic diaphragmatic hernia: Case report and literature review (Taylor, Watanabe, Chua)	230
--	-----

I

Intraoperative ultrasound of hepatic tumors (Boggs, Rouch, Chua)	496
---	-----

M

Maternal mortality in Indiana: A report of maternal deaths in 1990 (Ragan)	420
--	-----

N

New alternatives in gallstone treatment (Graffis, Jordan, Lingeman, Moster)	34
--	----

P

PCP presenting as cavitory pneumonia: A case report (Slama, Abels, Cox)	314
---	-----

FEATURES:

A

Annual reports	54, 146, 394
Avoiding false starts: Keys to a successful new practice (Condra, Metzger)	32

C

Commission studies Indiana health care delivery	378
Concern for patients helps physicians avoid lawsuit (Carlson)	112

D

Digest of health and medical laws	293
Doctor fills her life with favorite things	382
Doctor prescribes band aid for stress (Sims)	494

E

Ethical issues in withholding and withdrawing life-sustaining treatment (Gramelspacher)	218
---	-----

F

Friendly, efficient offices set trend for 1990s (Furore)	28
---	----

G

Gallup Poll reflects Indiana attitudes on health care	22
---	----

H

Health commissioner concerned about access to care (Carlson)	198
Health policy commission sees no easy answers (Carlson)	12
Helping patients receive Social Security benefits (Robison)	490
HIV/AIDS surveillance in Indiana (Fleissner)	486
HIV provider referral proves effective (Benyo)	120

I

IAFP leader dispels myths of family medicine (Carlson)	476
Indiana chosen for pilot project in risk management	206
Indiana residents polled on insurance, malpractice	130
ISMA Fifty Year Club	66
ISMA lobbying team plays offense, defense (Abrams)	26
ISMA successful during 1992 legislative session (Abrams)	228
IU dean examines primary care issue (Carlson)	278

M

Medical teams praised for rescue efforts (Bigham)	212
---	-----

N

New bloodborne pathogen rules become effective (Tutwiler)	128
New faces in statehouse may change ISMA strategy (Abrams)	302
New Medicare formula: RVU x GAF x CF = ?	20
1991 ISMA convention coverage	46
1991 ISMA convention highlights	42
1991 ISMA membership report	148
1992 annual convention & exposition	386

R

Rabies in Indiana: It's still a threat (Sinclair)	308
Recruiting doctors: Big job for small towns (White)	284
Resolutions	57, 408
Rural physicians have chance to make a difference (Sims)	288

S

Snakeroot Extract	141, 319, 423
Staff development: Making one plus one equal three (Kolbas, McWilliams)	124

V

Vagueness of OSHA rules concerns physicians (Ullman)	482
Valuing a practice for purchase or sale (Kolbas)	222

W

Woman physician sees need for mentors	370
Women in Medicine fact sheet	384
Working vacations in the Third World for physicians and dentists (Robinson)	312

DEPARTMENTS:

About the artist	149
Annual reports	54, 146, 394
Auxiliary report	67, 147, 234, 318, 428, 504
Commentary	474
CME awards	96, 176, 262, 352, 458, 536
CME calendar	94, 172, 257, 348, 454, 532
Correction	461
Drug names	95, 134, 227, 313, 429
Editorial	6, 106, 190, 192, 364, 366
From the museum	93, 171, 346, 452, 530
ISMA leadership	92, 179, 269, 276, 465, 505
Letter to the editor	11, 108, 196, 368, 472
News briefs	181, 265, 349, 455, 533
Obituaries	95, 174, 260, 350, 456, 534
People	96, 176, 262, 352, 458, 536
Resolutions	57, 408
Scientific commentary	500
Statement of ownership,	

management and circulation	506
Stethoscope	4, 104, 188, 274, 362, 470
What's new	173, 258
Wounded healer	68

AUTHORS:

A

Abels, Linda	314
Abrams, Mike	26, 228, 302

B

Benyo, Mary	120
Bigham, Polly	212
Blemker, David L.	136
Brown, John	414

C

Carlson, Bob	12, 112, 198, 278, 370, 476
Chua, Gonzalo T.	230, 496
Condra, Ernest	32
Cox, David	314

F

Faust, Sue	414
Fleissner, Mary Lou	486
Furore, Kathleen	28

G

Graffis, Richard	34
Gramelpacher, Gregory P.	218

J

Jordan, Lee	34
-------------------	----

K

Kesler, Kenneth A.	414
Kolbas, John W.	124, 222

L

Lingeman, James E.	34
-------------------------	----

M

McWilliams, Kathleen A.	124
Mahomed, Yousuf	414
Metzger, William	32
Moster, Mary Beth	34

O

O'Donnell, Jacqueline	414
-----------------------------	-----

R

Ragan, William D.	420
Rigden, L. Brick	414
Robinson, Robert D.	312
Robison, Steven K.	490

S

Sims, Tina	288, 382, 494
Sinclair, Charles L.	308
Slama, Thomas G.	314

T

Taylor, Barbara	230
Terry, Jean	378
Trippi, James A.	136
Turrentine, Mark W.	414
Tutwiler, William J.	128

U

Ullman, Kurt	482
--------------------	-----

W

Watanabe, Alan	230
White, Betty	284

NO AX TO GRIND.



Our occurrence policy has been the industry standard for nearly a century. But some doctors want a claims-made policy. So we have it available. At the Medical Protective Company, we have no ax to grind. You can

choose from a variety of programs, both occurrence and claims-made, that offer greater flexibility and savings. The choice is yours. Call us today.

THE
MEDICAL PROTECTIVE COMPANY

Vernon E. Hoover, H. Jere Frey, Michael W. Kinzer
6100 North Keystone Avenue, Suite 237, P.O. Box 20576, Indianapolis, IN 46220 • (317) 255-6525

Robert B. Newell, J. Barton Lyon
Suite 240, 2260 Lake Avenue, P.O. Box 5174, Fort Wayne, IN 46895 • (219) 422-4783

PHYSICIAN'S OFFICE FOR LEASE:

1,946+ square-foot free-standing building with parking lot, one block south of St. Francis Hospital Center, Beech Grove (Indianapolis), at the southeast quadrant of Sherman and Main, a stoplighted intersection, next to Lamping Cleaner's on the corner. Popular family physician's office for the past 26 years includes one public and two private entryways, large waiting room, receptionist and file area, two kitchen/lab rooms, five exam rooms, nurses' station, two private doctors' offices and two restrooms. For further information, please call the Fortuna 500 Company at (317) 887-0707.

INDIANA - Become the latest BE/BC addition to an energetic, five-member family practice group in a family-oriented community of 75,000 only 30 minutes northeast of Indianapolis. You will be associated with a young group of progressive family physicians in a recently built 10,500-sq.-ft. office (complete with full-service x-ray and lab) that is connected to a 207-bed community hospital. An outstanding financial package with partnership availability is being offered. For further information, contact Andrew Johns, Physician Services of America, Suite 250, 2000 Warrington Way, Louisville, KY 40222, or call 1-800-626-1857, ext. 237.

\$180K GUARANTEED: FPs/GPs earn great personal income and enjoy excellent call coverage. Benefit from major university within 20 minutes, two metro areas within 1 1/2 hours. Package includes attractive bonus, paid overheads and interview expenses. For more information, send your CV to Bill Cox of Harris Kovacs Alderman, 5420 Southern Ave. West, Suite 407, Indianapolis, IN 46241 or call 1-800-776-7901, ext. 2-024. You may also fax your CV to (317) 247-8533.

\$130K GUARANTEED: All family practices in town are full and payer mix includes 75% insurance.

Share 1:5 call in solo setting, associate with quality existing practice or work in satellite clinic. Beautiful lake nearby, three metro areas within one hour. Package includes paid overhead, bonuses and temporary housing. For more information, send your CV to Bill Cox of Harris Kovacs Alderman, 5420 Southern Ave. West, Suite 407, Indianapolis, IN 46241, or call 1-800-776-7901, ext. 0-0016. You may also fax your CV to (317) 247-8533.

PRACTICE FOR SALE: Munster, Ind. (outside Chicago). Established general practice. Office-based with focus on preventive, occupational and physical medicine. Four-year average net collections \$650,000 plus. For information, contact Mr. Rex Denkmann, (708) 759-1660, fax (708) 759-1661.

INDIANAPOLIS/TERRE HAUTE CORRIDOR - Practice and live minutes from two thriving metros. \$125,000 net, guaranteed for two years, up to \$40,000 bonus, plus paid moving, overheads and interview. OB a plus. Low HMO/PPO, high private pay ... net potential over \$200K. Full hospital support in starting your practice. Call Wes Mizelle at 1-800-776-7901, ext. 2-156, or send CV and phone number to Wes at Harris Kovacs Alderman, 5420 Southern Ave. West, Suite 407, Indianapolis, IN 46241.

FAMILY PHYSICIAN WANTED to join a two-physician group in west central Indiana. Salary negotiable. Call or write to Frank Swain, M.D., Parke Clinic, P.O. Box 185, Rockville, IN 47872, (317) 569-3182.

SOLO PEDIATRICS with coverage available. Kokomo is an excellent place to practice, having two fine hospitals, strong community spirit, four-year university and a solid industrial base. D.L. Fields, M.D., P.O. Box 2705, Kokomo, IN 46902.

SUBURBAN COLUMBUS, OHIO: Two orthopaedic surgeons - one general orthopaedist and one trained

in sports medicine - needed in a college town. Virtually instantly busy practice with a variety of cases and sports clinic, assured coverage, modern hospital, all M.D. anesthesia. Population 80,000 and expanding. Near Columbus with its major university, culture, shopping. Call Walter Smith, 1-800-221-4762.

SUBURBAN COLUMBUS, OHIO: Pediatrician seeks partner or overhead sharer for busy practice in college town. Population 80,000. 50-55 patients/day. 20-30 new-borns/month, 100 hospital admissions/year, one-month wait for well visit. 1:4 coverage. New building approximate to hospital with 1,400 deliveries. Near Columbus with its major university, culture, shopping. Call Walter Smith, 1-800-221-4762.

SUBURBAN COLUMBUS, OHIO: Dermatologist with two offices seeks partner or overhead sharer for busy practice in a college town. Sees 300 patients/week, some surgery, six weeks wait for appointment. Teaching appointment available. Near Columbus with its major university, culture, shopping. Call Walter Smith, 1-800-221-4762.

SUBURBAN COLUMBUS, OHIO: One of four busy OB/GYNs in this college town seeks a partner. Coverage from all OBs. 1,400 deliveries, surgery, LRDP, epidural service. 40-minute drive to Columbus: major university, shopping, culture. Call Walter Smith, 1-800-221-4762.

SUBURBAN COLUMBUS, OHIO: Another internist needed to join four others in a college town. Population 80,000 and expanding. Subspecialty and surgical back-up at modern hospital. Columbus and major university medical school 40 minutes away. Guarantee + office. Walter Smith, 1-800-221-4762.

SUBURBAN COLUMBUS, OHIO: In a college town, a busy general surgeon (four gallbladders/week, 10 major cases/week, 10 minor cases/

■classifieds

week, 300 endoscopies/year) seeks a general-vascular surgeon to take up the portion of practice not being done locally. Population of 80,000. 1:5 coverage. Modern hospital with all M.D. anesthesia. Near Columbus with its major university, culture, shopping. Call Walter Smith, 1-800-221-4762.

SUBURBAN COLUMBUS, OHIO: Another FP needed to join four others in a college town. Population 80,000 and expanding. Medical, OB and surgical back-up at modern hospital. Columbus and major university medical school 40 minutes away. Guarantee + office. Walter Smith, 1-800-221-4762.

CHIEF MEDICAL OFFICER for Department of Veterans Affairs, Adam Benjamin Jr. Outpatient Clinic in Crown Point, Ind. Immediate opening for qualified physician to manage satellite clinic of a university-affiliated, Chicago-based tertiary care VA medical center. Opportunity offers Northwestern University Medical School faculty appointment to qualified individual, regular hours, a state-of-the-art facility, on-site specialty services and a competitive salary. Position includes managerial duties, clinical practice and teaching. Research opportunities available. Qualifications include board eligibility/certification in a recognized medical specialty and U.S. citizenship or permanent alien status. Internist with previous management experience preferred. We are an Affirmative Action/Equal Opportunity Employer. Qualified women and minority candidates are encouraged to apply. Position is subject to drug screening. Send curriculum vitae to Raymond Zeiss, M.D., Acting Chief of Staff (11), VA Lakeside Medical Center, 333 E. Huron St., Chicago, IL 60611.

GENERAL INTERNISTS, full- or part-time, needed for the Department of Veterans Affairs Lakeside Medical Center in Chicago, Ill., and its satellite facility, the Adam Ben-

jamin Jr. Outpatient Clinic in Crown Point, Ind. Northwestern University Medical School faculty appointments are available to qualified persons. We offer regular hours, no in-house night call, challenging patients, on-site specialty services, modern facilities, well-trained colleagues and a competitive salary. Qualifications include board eligibility/certification in internal medicine and U.S. citizenship or permanent alien status. We are an Affirmative Action/Equal Opportunity Employer. Qualified women and minority candidates are encouraged to apply. Successful applicants may be asked to undergo drug screening as a condition of employment. Send curriculum vitae to Ken Khuans, M.D., Acting ACOS for Ambulatory Care (11C), VA Lakeside Medical Center, 333 E. Huron St., Chicago, IL 60611.

EMERGENCY CARE PHYSICIANS – Expanding emergency medicine group seeking career-minded physicians for multiple Indiana locations. Twenty-year history without a lost contract. Hourly compensation based on training, experience and qualifications. Excellent benefits include 401(k) pension plan; malpractice, health, life and disability insurance; CME allowance; and ACEP, ISMA and hospital dues. Will consider all physicians with emergency medicine experience and interest. Contact Jim Gardner, M.D., Director, Corporate Development, Emergency Care Physicians, 640 S. Walker St., Suite A, Bloomington, IN 47403, (812) 333-2731.

IMMEDIATE CARE PHYSICIANS – Expanding immediate care group seeks career-minded primary physicians for multiple Indianapolis locations. Corporation is physician-owned and operated with 11 years of experience in Indianapolis metropolitan area. Compensation based on training, experience and qualifications. Excellent benefits include 401(k) pension plan; malpractice, health, life and disability

insurance; CME allowance; and ACEP, ISMA and county dues. Will consider all primary medical disciplines with interest in outpatient medicine. Full-time opportunities only. Contact Jim Gardner, M.D., Director, Corporate Development, Emergency Care Physicians, 640 S. Walker St., Suite A, Bloomington, IN 47403, (812) 333-2731.

OHIO-WISCONSIN-MICHIGAN-MISSOURI – Attractive opportunities in metropolitan and scenic recreational areas. Locations near pristine lakes, white water rivers and national forests. Others in college communities offering professional and Big 10 college sports, fine arts and a broad spectrum of nationally renowned CME programs. Positions available: allergy, dermatology, neurosurgery, occupational medicine, oncology, orthopaedics, otolaryngology, psychiatry, rheumatology and urology. To discuss your practice preferences and these opportunities, please call our toll-free number, 1-800-243-4353, or send your CV to STRELCHECK & ASSOCIATES, INC., 10624 N. Port Washington Road, Mequon, WI 53092.

INTERNAL MEDICINE, FAMILY PRACTICE, URGENT CARE, OB/GYN AND ACADEMICS: Positions in large metropolitan cities, urban and rural communities with a concentration in the Great Lakes area and Plains states. Whether you prefer a cosmopolitan lifestyle, a city surrounded by nature and the beauty of the four seasons, the peaceful rolling farm country or perhaps life in historic villages – there is something for everyone. To discuss your practice preferences and these opportunities, please call our toll-free number, 1-800-243-4353, or send your CV to STRELCHECK & ASSOCIATES, INC., 10624 N. Port Washington Road, Mequon, WI 53092.

PHYSICIAN PRACTICE OPPORTUNITIES – Statewide/nationwide/worldwide. All specialties, group/solo, varied income arrangements.

Contact Larson & Trent Associates, Box 1, Sumner, IL 62466-0001. Telephone: (618) 936-2662, 936-2970 or (800) 352-6226.

RADIOLOGY – Seven-person group is seeking an eighth radiologist with special interest in cross-sectional imaging. The Department of Radiology is expanding, is well-staffed and has all new and modern equipment. The initial salary is competitive, with a guaranteed bonus. The all-inclusive benefits are generous, with partnership potential. The excellent practice opportunity offers suburban living at its best and is located 45 minutes from downtown Chicago. For further information, please contact Peter E. Doris, M.D., Chairman, or Antigonis Kencos, M.D., Vice Chairman, Department of Radiology, St. Anthony Medical Center, Crown Point, IN 46307, (219) 757-6320.

FAMILY PRACTICE opportunities available in Fort Wayne, Ind. Practice setting extremely flexible. Solo or group. Salary guarantee, relocation and other expenses paid. An opportunity to practice medicine and leave administrative and billing headaches to someone else. For complete details, contact our physician recruiting officer at (219) 489-2772, ext. 415.

FAMILY PRACTITIONERS/INTERNISTS – MetroHealth, an affiliate of Methodist Hospital of Indiana, Inc., is seeking board-certified/eligible family practitioners and internists. Share the advantages of joining an established prepaid multi-specialty physician group offering an ideal blend of practice and lifestyle, paid professional liability and competitive compensation and fringe benefit packages. Our practice is located in Indianapolis, a thriving Midwest community offering a number of cultural, educational and recreational activities. For confidential consideration, submit curriculum vitae to

MetroHealth Physician Recruitment, P.O. Box 1367, Indianapolis, IN 46206.

MULTIPLE AND VARIED physician practice opportunities currently exist both within and outside Indiana. Call Patti Quiring at work, (317) 841-7575, or at home, (317) 823-4746. Patti is a physician recruiter for Quiring Associates, an executive search firm headquartered in Indianapolis.

GENERAL INTERNIST – BC/BE. To join a busy five-man practice with special interest in hospital intensive care, plus consultative and primary care practice in the Indianapolis area. Will offer partnership. Reply to Box 19616, Indianapolis, IN 46219.

EMERGENCY MEDICINE – Terre

Haute, Ind. Local multi-hospital group seeking full-time career-oriented emergency physician for position in small- and medium-volume community hospitals. Flexible scheduling, very competitive compensation package, partnerships available. Send CV or contact William R. Grannen, Priority Health Care, P.C., 7179 Lamplite Ct., Cincinnati, OH 45244, (513) 231-0922.

CENTRAL INDIANA – Physician-owned emergency group accepting applications for full-time, career-oriented emergency physicians. Flexible work schedules and excellent benefit package. Part-time and directorship positions also available. Send CV or contact Midwest Medical Management, Inc., 3645 S. East St., Indianapolis, IN 46227-1240, (317) 783-7474. □

Classified advertising rates

Classified advertisements are published as a service to members of the Indiana State Medical Association. Only ads considered to be of advantage to members will be accepted. Advertisements of a truly commercial nature (ie: firms selling brand products, services, etc.) will be considered for display advertising. All orders must be in writing and will automatically be set in regular classified type. Box numbers are not available.

Charges:

- * ISMA members25¢/word (\$15 minimum)
- * Non-members75¢/word (\$30 minimum)

Deadline: Six weeks preceding month of publication.

Payment procedure: Payment in advance is not required. Invoices and tearsheets are mailed to advertisers upon publication. INDIANA MEDICINE is issued on the 10th of the month six times a year, in January, March, May, July, September and November.

Address: INDIANA MEDICINE, 322 Canal Walk, Indianapolis, IN 46202-3252.

Advertisements for employment containing specifications as to race, creed, color, age, religion, sex, ethnic origin or national origin may be unlawful and professionally improper. Accordingly, discriminatory wording is not acceptable in INDIANA MEDICINE. In such a case, INDIANA MEDICINE will modify the wording and notify the advertiser of the change.



"Ron's Rule—I give myself one week to meet new people and start having fun on a locum tenens assignment. It hasn't failed me yet."

Ron Richmond, MD, joined the CompHealth locum tenens medical staff when he completed his residency. He loves to meet people.

A little time off sounded

really good. And he thinks being exposed to different types of medical practice will serve him well when he returns to his hometown to establish a community health center.

A singer. A board-certified family practitioner. Soft-spoken for a New Yorker. Ron Richmond knows...

It's a great way to
practice medicine

CompHealth

LOCUM TENENS

1-800-455-5050

Salt Lake City ■ Atlanta ■ Grand Rapids, Mich.

Mark Your Calendars!

Plan to attend the ISMA legislative reception Jan. 27.

The annual reception will be held from 6 p.m. to 8:30 p.m. at the Westin Hotel in Indianapolis. This year's theme is "Escape to the Islands."

For more information, call Susan Grant at the ISMA, (317) 261-2060 or 1-800-257-4762.

Advertising index

Affiliated Physicians Services	Cover
Arnett Clinic	473
Auto Buyers Network	535
Central Pharmaceuticals	503
CompHealth	546
Lilly, Eli & Co.	471
Medical Accounts Group	499
Medical Protective	542
Palisades Pharmaceuticals	468
Physicians' Directory	507
Physicians Insurance Co. of Indiana	Cover
Physician International	472
G.D. Searle and Company	Cover
Speedway Mazda	485
University Place	469
U.S. Air Force	531

In accepting advertising for publication, INDIANA MEDICINE has exercised reasonable precaution to ensure that only reputable, factual advertisements are included. However, we do not have facilities to make comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services, medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertisers only. Neither sanction nor endorsement of such is warranted, stated or implied by the association.

Are you moving?

If so, please send change of address to the Indiana State Medical Association, Membership Department, 322 Canal Walk, Indianapolis, IN 46202-3252, at least six weeks before you move.

Name: _____

Address: _____

City: _____

State: _____ Zip: _____ County: _____

Office phone: _____ Home phone: _____

IMPORTANT - Attach mailing label from your last copy of INDIANA MEDICINE here:

ISMA Health/Dental Insurance

Benefits available to members of the Indiana State Medical Association and their employees through expanded ISMA group sponsored health insurance.

MEDICAL PLAN A

- 365 Days of Inpatient Hospital Care
- 100% payment semi-private or hospital ward room
- 365 Days In-Hospital Medical Care
- 100% reasonable and customary allowances for surgery, maternity, general anesthesia, medical visits, radiation therapy, and other eligible inpatient hospital charges
- \$2,000,000 Major Medical Benefits (\$100 deductible)

MEDICAL PLAN B

- Comprehensive Major Medical protection
- \$250 calendar year deductible, \$500 per family
- Stop-Loss Limit \$5,000 per person, \$10,000 per family
- PCS Card
- Includes cost-containment features
- \$2,000,000 Maximum Benefits

MEDICAL PLAN C

- Comprehensive Major Medical protection
- \$500 calendar year deductible, \$1,000 per family
- Stop-Loss Limit \$5,000 per person, \$10,000 per family
- \$2,000,000 Maximum Benefits

MEDICAL PLAN D

- Economical Comprehensive Major Medical protection
- \$1,000 calendar year deductible, \$2,000 per family
- Stop-Loss Limit \$5,000 per person, \$10,000 per family
- \$2,000,000 Maximum Benefits

MEDICAL PLAN E

- Low cost Comprehensive Major Medical protection
- \$2,000 calendar year deductible, \$6,000 per family
- Stop-Loss Limit \$10,000 per person, \$30,000 per family
- \$2,000,000 Maximum Benefits

BENEFITS FOR ORGAN OR TISSUE TRANSPLANTS

- Included with all medical plans
- Subject to normal plan deductibles and co-insurance
- Covered Transplant Procedures: This benefit covers any of the following human to human organ or tissue transplants: bone marrow; heart; heart/lung; liver; kidney; cornea
- Artery or vein transplants
- Joint replacements
- Heart valve replacements
- Implantable prosthetic lenses in connection with cataracts
- Prosthetic by-pass or replacement vessels
- Maximum Transplant Benefit: \$1,000,000 lifetime maximum per person for all transplant services

DENTAL PLAN

- Reasonable and customary allowances for necessary care and treatment for dental health - \$50 calendar year deductible, \$100 per family
- \$1,500 maximum dental benefit per person in a calendar year paid at 80%, additional major dental paid at 50%
- \$1,000 Orthodontia Benefits paid at 50% of reasonable and customary charges

MEDICAL REIMBURSEMENT PLAN

- Tax deductible to the professional corporation

Your benefit programs have been designed to provide the highest quality coverage and service at the lowest possible cost. A special claim paying unit has been established to handle only the ISMA program. Should you have questions or problems, you may speak directly to your claim processor. We look forward to serving you and encourage your review of the program and services being provided.

For more information regarding these coverages contact:

Tom Martens
Director, Health Insurance Administration
Indiana State Medical Association
322 Canal Walk
Indianapolis, Indiana 46202-3252
(317) 261-2060
800-257-ISMA
FAX (317) 261-2076

Earl W. Williams
Professional Account Representative
11595 N. Meridian St., Suite 802
Carmel, Indiana 46032
(317) 573-6520
800-421-3020
FAX (317) 573-6524

AFFILIATED PHYSICIANS SERVICES, INC.

ISMA Agency

For the many faces of mild hypertension



THE MOST WIDELY USED CALCIUM ANTAGONIST AS MONOTHERAPY FOR MILD HYPERTENSION^{1*}

- Effective 24-hour control²
- Single-agent efficacy
- Well tolerated³
- No adverse effects on total cholesterol, plasma glucose levels, renal function,⁴ or serum electrolytes^{5,6}



For the many faces of mild hypertension

*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see **Warnings**), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents.

References: 1. Data on file, Searle. 2. Edmonds D, Wurth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbo KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmelder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbo K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:1025-1029.

Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°:2°:3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

2/13/92 • P92CA7196V

Address medical inquiries to:
G.D. Searle & Co.
Medical & Scientific
Information Department
4901 Searle Parkway
Skokie, IL 60077

SEARLE

Box 5110
Chicago, IL 60680-5110



